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MEDICAL ASSISTANCE FOR THE AGED

THE KERR-MILLS PROGRAM
1960–1963

A REPORT

BY THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

TO THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

TOGETHER WITH

MINORITY, INDIVIDUAL, AND SUPPLEMENTAL VIEWS

OCTOBER 1963

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LETTER OF TRANSMITTAL

U.S. SENATE,
October 22, 1963.

Hon. GEORGE A. SMATHERS,
Chairman, Special Committee on Aging,
U.S. Senate.

DEAR MR. CHAIRMAN: I have the honor to transmit herewith the report of the Subcommittee on Health of the Elderly evaluating the program of Medical Assistance for the Aged.

This program, generally referred to as the Kerr-Mills Act, has been the subject of continuing and careful appraisal by the Special Committee on Aging since its enactment by the Congress in 1960. The current report, which includes individual and minority views, updates and substantially expands upon earlier studies of the operation of the Kerr-Mills MAA program.

This report should be of assistance to the Members of the Congress in their consideration of the several legislative proposals which have been introduced in response to widespread public interest and concern with the need for effective and adequate methods designed to help older Americans meet the heavy expenses of health care.

With all good wishes,

Sincerely,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

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INTRODUCTION

After 3 years of operation, the Kerr-Mills Medical Assistance for the Aged (MAA) program has proved to be at best an ineffective and piecemeal approach to the health problems of the Nation's 18 million older citizens.

Since the Kerr-Mills program of Medical Assistance for the Aged took effect on October 1, 1960—3 years ago—the Special Committee on Aging, and its predecessor, the Subcommittee on Problems of the Aged and Aging of the Senate Labor and Public Welfare Committee, have closely observed its operation and have periodically issued reports evaluating the program.[1]

This report of the Health Subcommittee of the Special Committee on Aging is the third such evaluation of the Kerr-Mills program, and is based upon study and appraisal of all available information.

The findings of this report confirm the conclusions of earlier studies that the MAA program did not, and could not by itself, constitute an effective national solution to the pressing and pervasive problems connected with the financing of the hospital and related expenses of the Nation's senior citizens.

The findings set forth in "Performance of the States," the 1962 staff report of the Special Committee on Aging, have proved to be still valid. Additional findings and new data have been added.

In brief, we find that the Kerr-Mills program of Medical Assistance for the Aged, still suffers from these major defects:

1. After 3 years it is still not a national program, and there is no reason to expect that it will become one in the foreseeable future. Although all 50 State legislatures have met since this program was enacted into law, 3 years ago, only 28 States and 4 other jurisdictions now have the program in operation.

2. Stringent eligibility tests, "lien type" recovery provisions, and responsible relative provisions have severely limited participation in those jurisdictions where the program is in operation. In August of 1963, only 148,000 people received MAA assistance—or less than 1 percent of the Nation's older citizens.

3. The duration, levels and types of benefits vary widely from State to State. Except for those four States having comprehensive programs (Hawaii, Massachusetts, New York, and North Dakota) benefits are nominal, nonexistent, or inadequate.

4. Administrative costs of MAA programs remain too high in most jurisdictions. In Tennessee, for example, administrative costs totaled 59 percent, while in four other States they exceeded 25 percent of benefits.

5. The distribution of Federal matching funds under MAA has been grossly disproportionate, with a few wealthy States, best able to finance their phase of the program, getting a lion's share of the funds. Five States, California, New York, Massachusetts, Michigan, and

[1] "Performance of the States, 18 Months of Experience With the Medical Assistance for the Aged (Kerr Mills) Program," June 15, 1962. "State Action To Implement Medical Programs for the Aged," June 8, 1961.

Pennsylvania, for example, received 88 percent of all Federal MAA funds distributed from the start of the program through December 31, 1962, although those five States have only 32 percent of the Nation's elderly people. New York alone, with 10 percent of the Nation's elderly, received 42 percent of this total.

6. The congressional intent to extend assistance to a new type of "medically indigent" persons through MAA has been frustrated by the practice of several States in transferring nearly 100,000 persons already on other welfare programs, mainly OAA, to the Kerr-Mills program. The States have done this to take advantage of the higher matching grant provisions of Kerr-Mills, saving millions of dollars in State costs, but diverting money meant for other purposes.

7. The "welfare" aspects of the Kerr-Mills MAA program, including cumbersome investigations of eligibility, plus the requirement in most States that resources of an older person must be depleted to a point of near-dependency, have further reduced participation.

SUMMARY

INTENT OF THE KERR-MILLS MAA LEGISLATION

The Kerr-Mills Act has two facets—one representing a relatively minor improvement in the already existing program of aid for people on Old-Age Assistance (OAA), and the other representing a major innovation.[2] The primary feature of Kerr-Mills was the establishment of a new category of public assistance—Medical Assistance for the Aged. This program, popularly known as Kerr-Mills MAA, offered an opportunity for the States to secure substantial Federal grants applicable—on a matching basis—toward meeting the medical expenses of older citizens who had previously been ineligible for help—the "medically indigent" aged. The "medically indigent" aged are those persons who are not on the Old-Age Assistance rolls, but who are unable to cope with the costs of health services.

It was the intent of the Congress that the MAA program would provide broad health services to the many aged needing them but unable to afford them even though the individuals were not on welfare.

Achievement of such a goal for MAA would require that (1) all States establish MAA programs, (2) the programs include a comprehensive range of medical services consistent with the needs created by the poorer health generally suffered by the aged, (3) the eligibility requirements be realistic in terms of the health expenses and financial resources of the aged, and (4) the assistance be made available without humiliating or degrading our older people.

The evidence available after 3 years of Kerr-Mills operation, demonstrates conclusively that the congressional intent has not and will not be realized, with respect to any of these four goals.

LIMITED USE OF THE ACT

Many States have not implemented the MAA program. As of the end of August 1963, only 28 States and 4 other jurisdictions had MAA plans in operation. Indications are that by the end of 1964, from one-fifth to one-third of the States still will not have MAA plans in operation.

In those States which have established MAA plans, implementation is, in many instances, nominal, because of a lack of State funds to finance the type of program that is required. Many States which have established MAA plans still do not meet what they themselves say are the basic needs (not including health needs) of those of their citizens who are on relief.

Only 148,000 aged persons received any MAA help in August 1963—less than 1 percent of the Nation's elderly. And many thousands of these people had received care or were eligible for care under relief programs existing before enactment of Kerr-Mills.

[2] Since 1950 the Federal Government has assisted the States with funds to be used toward payments to suppliers of medical care for people on relief. The first part of the Kerr-Mills Act simply increased the amount of Federal funds available for that purpose under the program of old-age assistance.

Even according to the most conservative estimates, probably well over one-half of all applications approved for MAA through September 1962 were submitted in behalf of people previously receiving or eligible for medical aid under a public program other than Kerr-Mills.

As a result of the use of means tests for MAA which are almost as strict as those for OAA, the number of people who can receive help is severely limited.

THE MEANS TEST

"So that the county board of assistance can decide as fast as possible whether you are eligible for MAA, be ready when you apply to give them the facts on your age, residence, amount of income, and value of property. It may help if you bring papers that give this information. Also have with you the names and addresses of your husband or wife, your sons and daughters."[3]

MAA programs require an applicant to submit to a means test—an investigation of his income and assets. The means test is the basis of all relief programs. In most States, the highly restrictive nature of the tests, apart from any degrading qualities, exclude from help many of the aged who are desperately in need of assistance. There are at least 14 States in which the means test for MAA would serve to eliminate many of the aged people who qualify for other relief programs in those States.

Twelve States have "family responsibility" provisions which, in effect, also impose means tests upon the relatives of those who might be tempted to seek aid from the MAA program. These provisions not only are disruptive of familial relationships, but deter many proud people from seeking the care they need because they do not want to involve their families. "A number of elderly persons in Buffalo, when informed of this provision reportedly told the welfare commissioner, 'Please kill my application. * * * I don't want my son questioned.' "[4] The welfare commissioner of the city of New York has stated: "I believe that this requirement serves to bar uncounted, truly needy, older persons from seeking medical aid under this program."[5]

Nine States—including those with by far the largest number of people receiving help under Kerr-Mills MAA—have recovery provisions in their programs extending to the homes of people receiving help, and collectible after death. Since Americans of retirement age equate "free and clear" ownership of one's home with self-respect, the idea of a State taking a claim on that home is completely abhorrent to them. This further restricts participation in the program.

"Means test medicine" requires that the applicant for MAA shroud himself in the welfare cloak. He must state, and in many jurisdictions his relatives are also required to reveal, the precise amounts and sources of his income, and the value of each asset. In "means test medicine," far too much emphasis is placed upon the means test and not enough upon the medicine.

[3] "If You Need Medical Assistance for the Aged," informational leaflet No. 8, Commonwealth of Pennsylvania, Department of Public Welfare, March 1962.
[4] Quoted by Senator George R. Metcalf in "New York's Medicare Plan," Hospital Topics, October 1962.
[5] At hearing of New York State's Joint Legislative Committee on Health Insurance Plans, Nov. 16, 1962.

LIMITATIONS ON BENEFITS

Having navigated the eligibility maze, the applicant's expectation of relief is all too often not realized. Frequently, assistance available is totally inadequate. For example:

> Question. "In Kentucky, what happens if the hospital patient is still sick after 6 days?"
> Answer. "We pay only for 6 days. If the patient is in the hospital longer, the care may be paid for by a relative or a charity, or the hospital may discharge him. We do not know what happens after our responsibility is met." [6]

Many States participating in MAA sharply limit their programs in terms of types of services provided and the duration or quantity of care supplied, in addition to specifying that benefits will be available only for certain kinds of illness or injury.

Only four States—Hawaii, Massachusetts, New York, and North Dakota—have plans which meet the Department of Health, Education, and Welfare's definition of a comprehensive health program. And in Hawaii, Massachusetts, and New York only 2 percent or less of total payments was for physicians' services—hardly indicative of comprehensive coverage of physicians' care.

Where nursing home care is provided, the payments are often no more than enough to provide a poor quality of custodial care and are totally insufficient to pay for any skilled nursing care. Custodial care is not medical care.

In some States, the medically indigent person is required to pay cash contributions from his meager resources toward the cost of care. In some States, he must make such payments before he can even qualify for MAA help. Louisiana's Department of Public Welfare even permits hospitals to collect from the MAA recipient and/or his relatives the difference between the amount billed and the allowance paid by the welfare fund. Use of such deductible and contributory provisions is particularly inappropriate, contradictory, and self-defeating in a program which has already employed a means test to prove inadequacy of resources, and for which the Congress has forbidden use of any "enrollment fees, premium, or similar charges."

FREEDOM OF CHOICE RESTRICTED

Even those relatively few aged persons who are declared eligible for limited help under MAA are not always able to get the care they need. In some cases, they cannot get care from the doctors of their own choice.

The limitations in the scope and levels of care in many of the MAA programs adversely affect the quality of care provided, the patient's freedom of choice, and the doctor's freedom to treat his patients in an individual. way. They are dependent upon the willingness of hospitals and physicians to accept MAA payments—which are often below the "going" rates. In one State, for a while, some doctors and hospitals refused to participate in the MAA program because the State found it necessary to reduce fees paid.

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[6] Response to question was made by Kentucky's commissioner of economic security at the 5th Annual Medical Services Conference of the Council on Medical Service of the American Medical Association, Nov. 25, 1962. The theme was "Kerr-Mills in Action—1962." The number of days of hospital care provided in Kentucky has since been increased to 10.

At least four of the jurisdictions with MAA plans require that services be secured from specified physicians or facilities only. As a practical matter, the failure of many jurisdictions to cover in-hospital physicians' services means that a large percentage of MAA recipients must depend upon the services of hospital and clinic staff doctors. Half of the physicians in Louisiana, for example, do not participate in the MAA program.

Unfortunately, the "freedom of choice" and the quality of care envisaged are dependent upon much more liberal financing of MAA programs. Unfortunately, also, most of the States cannot generate the matching funds necessary for a comprehensive program.

DISTORTION OF CONGRESSIONAL INTENT

Total MAA expenditures (Federal and State) from the inception of the program through August 1963 were $580 million. Not even this thoroughly inadequate sum (total payments for 2½ years amounted to one-tenth of yearly medical costs for persons over age 65) represents exclusively new expenditures for a new program.

MAA money has been and is being used to pay for care for nearly 100,000 persons previously aided under other relief programs. On the basis of the income tests for old-age assistance, tens of thousands of additional recipients of MAA would have been eligible for care under OAA had the MAA program not been enacted.

It was not the intent of Congress when it authorized MAA that new Federal funds be used to relieve States and communities of a responsibility which they had already accepted. Congress intended that this help be extended to an entirely new group of citizens—not to those already on relief or who would be eligible for relief. Congress offered to assume the major share of a new responsibility in the belief that the States would be eager to assume the rest.

Despite the clear expressions of congressional intent that this was not to be a program in lieu of existing OAA medical care plans, a number of States, by their actions, clearly thwarted and distorted what was intended.

The motive is clear—the Federal matching formula under MAA is more generous than under OAA.[7] The method is simple—drop skilled nursing home care, for example, from the OAA program and transfer coverage for that service to the MAA program. Now, the OAA recipient in need of nursing home care cannot be provided the care he needs, for OAA no longer includes that service. A few forms are completed and the OAA recipient is swiftly transformed into an MAA recipient. The clear intent of the Congress is violated by these paper transactions.

A dramatic example of the impact of this policy of transferring responsibility for care from OAA to MAA recently occurred in the State of Washington. That State reported a total of $187,559 paid in behalf of 1,176 recipients of MAA during the month of May 1963. For the month of June 1963, however, Washington reported total payments of $1,282,149 for care of 9,623 recipients of MAA.

[7] The Federal Government will match up to a maximum of $15 of vendor payments for medical care under OAA. However, under MAA, there is no limit on the amount of vendor payments subject to Federal matching.

State officials explain that this tremendous increase in MAA payments and recipients was caused by the transfer of recipients of long-term nursing home care under the Old-Age Assistance (OAA) program to Washington's MAA plan.

These transfers are totally inconsistent with the intent of the Congress when it enacted Kerr-Mills. A recent article analyzing the Kerr-Mills MAA program in Connecticut appeared in the August issue of the authoritative journal Hospital Progress. The authors, Albert W. Snoke, M.D., and Parnie S. Snoke, M.D., had this pertinent remark to make concerning the matter of transfer of assistance recipients to MAA:

> In this preliminary and tentative study of MAA in Connecticut, it is apparent that the program is an extension of an existing welfare program for health care of the needy aged. A large percentage of patients previously receiving assistance through OAA have been transferred to MAA. The caseload in Connecticut is steadily increasing.

UNEVEN DISTRIBUTION OF FEDERAL FUNDS

While the formula under which Federal grants are made to the States was intended by Congress to favor the States with low per capita incomes—where needs are greatest—in actual practice, a few wealthier States are getting the lion's share of MAA funds.

Some of the States with the lowest per capita incomes in the Nation are, in effect, contributing toward the cost of MAA programs in the wealthier States—while their citizens receive in some cases nothing, in others relatively little in return.

This result is not necessarily due to a lack of willingness on the part of the less wealthy States to do more for their older citizens, but is a consequence of the far greater tax bases in the wealthier States.

Nearly 88 percent of the $189 million in Federal funds allocated from the inception of the MAA program through December 1962 went to just five States—California, Massachusetts, Michigan, New York, and Pennsylvania. However, only 32 percent of the older population of the Nation reside in those five States.

This disproportionate sharing may well continue over the long run.

HIGH ADMINISTRATIVE COSTS

MAA's unavoidable administrative expenses constitute a substantial drain upon the limited resources of the States, which might otherwise be devoted to purchasing health care. In five States, such expenses ranged from 25 to 59 cents for each dollar actually spent on medical care in 1962.

In general, those States which have the highest costs of administration are the States which can least afford the expense—those with very low per capita incomes. The Federal Government pays only 50 percent of the costs of administration while it may pay as much as 80 percent of the dollars going for actual medical care. Thus, only a relatively small portion of a State's funds may go for medical care when substantial amounts have to be allocated to administrative costs.

As compared with a program based upon use of the social security mechanism and with no means test, it costs a great deal of money to

administer a program with the complex limitations on eligibility and benefits inherent in the MAA program.

In five States, administrative costs in 1962 for each applicant approved for MAA averaged over $100. The average cost per approved applicant in all States with MAA plans was $70.

In contrast, a social security-financed program would not spend millions in investigating income and assets of applicants and their relatives. The administrative expenses of such a program, estimated at 3 percent, would relate mainly to the procedure for making payments of hospital and related benefits, not to the determination of eligibility.

CONCLUSION

In conclusion, 3 years of experience indicates clearly that the strained financial resources of the States—and the competition for those funds by other urgent public needs such as education, housing, roads, etc.—make the well-intentioned aims of the Kerr-Mills MAA legislation impossible of realization in all of the States in the Union.

This experience proves that Kerr-Mills cannot, of itself, solve that problem which we have found to be the most persistent and frightening one confronting millions of older people in all parts of the country—the problem of assuring economic access to adequate medical care on a decent, self-respecting basis.

CHAPTER I

AVAILABILITY OF KERR-MILLS MEDICAL ASSISTANCE FOR THE AGED

Previous reports have called attention to several areas of misunderstanding concerning the Kerr-Mills program of medical assistance for the aged which have obscured and inhibited objective evaluation of the program. These confusions persist. Among these are the number of States which have actually established plans; the number of older persons who receive some help; and where responsibility lies for promotion of the program. These important questions are considered here.[1]

1. NUMBER OF STATES IMPLEMENTING KERR-MILLS

Much of the misunderstanding as to the number of States which have implemented the Kerr-Mills legislation arises from failure to distinguish between the two facets of Kerr-Mills: (1) The new Federal-State program of medical assistance for the aged (MAA) and (2) increased Federal support of medical care for recipients of old-age assistance (OAA) under the basic vendor payment provisions enacted by the Congress in 1950.[2]

We are, in this report, concerned only with the Kerr-Mills MAA program. The other phase of Kerr-Mills represents only one of a series of congressional acts liberalizing Federal sharing in relief programs. It does not represent a new departure and did not purport to be part of a new program to resolve a basic problem in financing the health care of the aged.

The primary purpose and new feature of Kerr-Mills was the provision by the Federal Government of an opportunity for the States to secure substantial Federal grants applicable toward meeting the medical expenses of older citizens who had previously been ineligible for such assistance—the medically indigent aged. The extent to which this purpose has been achieved is the principal measure of the accomplishments of the Kerr-Mills legislation.

A salutary effect, apparently resulting from the earlier efforts of the special committee to clarify the matter, has been a noticeable slackening in attempts to combine in a single total those States making some improvements in their OAA plans with those States establishing new MAA plans.[3] Statements such as "Kerr-Mills is now being put into

[1] We wish to acknowledge the cooperation of the Bureau of Family Services in the Welfare Administration of the Department of Health, Education, and Welfare in the assembly of data for this report. Within the Bureau we want to recognize particularly the contributions of Mr. Garnett Lester, who supervised the development and preparation of much of the statistical data and tables, and Mrs. Catherine Miller, who was responsible for the drafting of State program descriptions and certain of the tables.

[2] Three methods are employed to pay medical care costs of recipients of public assistance: (1) The "vendor payment" method consists of direct payments to hospitals, doctors, and other suppliers of medical care; (2) the "money payment" method is a system whereby a monthly cash grant is made to a recipient for his basic living expenses including a specific amount allocable for his medical requirements; (3) the third method consists of a combination of the first two. The Kerr-Mills legislation applies only to expenditures made under the "vendor payment" method.

[3] It might be appropriate to note that in order to secure any payments for medical care under an OAA program, the older person must go onto the relief rolls. He must satisfy, where applicable, residence requirements, be subject to current liens on his property, and possibly have his name on a list, to which the public has access, of people on relief. All of these provisions are expressly prohibited from use in Kerr-Mills MAA.

operation in 46 States," appear much less frequently than was formerly the case.

Nonetheless, these misleading claims still crop up. For example, a Member of the House of Representatives, in a speech on the floor of the House said recently:

> It is interesting to me to note that as a result of actions this year by State legislatures, nearly 95 percent of persons over 65 live in States in which the Kerr-Mills program is in operation. This to me certainly gives us reason to question the need for any new program which in itself is limited as to the persons who would be covered.

As will be shown in this report, that "95 percent" certainly do not live in States with Kerr-Mills MAA programs. And within those States which have MAA programs in operation, limitations as to persons eligible and benefits provided are all too real facts of life, which seemingly should serve to temper statements such as that quoted above.

Other sources of confusion in the determination of the precise number of States which have MAA plans in operation may result from:

(1) Counting as States, Guam, the Virgin Islands, Puerto Rico, and the District of Columbia, all of which have functioning MAA plans.

(2) Inclusion among the States with MAA programs, of States such as Georgia, New Mexico, and Nevada, which have enabling legislation, but where no funds were available for payments.

The fact is, that as of August 31, 1963, MAA programs were approved and known to be in operation in exactly 28 States, Guam, the Virgin Islands, Puerto Rico, and the District of Columbia. Table I notes the status of implementation of MAA among the various States as of August 31, 1963.

TABLE I.—*Activities of the 54 jurisdictions to put into effect the program of medical assistance for the aged, August 31, 1963*

A. Programs in effect (32): [1]

Alabama	Louisiana	Pennsylvania
Arkansas	Maine	Puerto Rico
California	Maryland	South Carolina
Connecticut	Massachusetts	Tennessee
District of Columbia	Michigan	Utah
Florida	New Hampshire	Vermont
Guam	New Jersey	Virgin Islands
Hawaii	New York	Washington
Idaho	North Dakota	West Virginia
Illinois	Oklahoma	Wyoming
Kentucky	Oregon	

B. Plan submitted; not in effect (1): South Dakota.[2]

C. Plan being drafted (1): Iowa (effective July 4, 1963).

D. Legislation enacted; plan not yet submitted (6):

Kansas (effective Jan. 1, 1964)
Minnesota (effective July 1, 1964)
Nebraska (effective Oct. 1, 1963)
North Carolina
Virginia (effective, Jan. 1, 1964)
Wisconsin (effective, July 1, 1964)

[1] Plans of these States are approved by HEW.
[2] To become effective upon approval of State's plan by HEW.

E. Need legislation (12):

Alaska	Indiana [4]	Nevada [5]
Arizona [3]	Mississippi	Ohio [3]
Colorado [3]	Missouri [4]	Rhode Island [3]
Delaware	Montana [4]	Texas [6]

F. Have authority for MAA; implementation indefinite (2):

Georgia: Enacted 1961; no funds available.
New Mexico: Has legal authority; 1963 appropriation request denied.

[3] Considered by 1963 legislature; not enacted.
[4] Vetoed by Governor.
[5] Enacted 1963, but contingent upon voter approval of sales tax increase to finance program—rejected by voters in June 1963 referendum.
[6] Passed resolution for constitutional amendment, which, if ratified by popular vote, may be followed by enabling legislation.

Source: Bureau of Family Services, Welfare Administration, Department of Health, Education, and Welfare.

Two additional States are expected to have MAA plans in operation by the end of 1963. With these new States—Iowa and Nebraska—30 of the 50 States will have implemented Kerr-Mills.

As table I reveals, prospects are that by the end of 1964, some five or six other States may have operative MAA plans. It is anticipated, therefore, that more than 4 years after enactment of Kerr-Mills, some 10 to 15 States will not have implemented the program.

Nonimplementation, of course, means that almost none of the older citizens in the States concerned receive any help. Implementation, by itself, on the other hand, cannot possibly be used to conclude that those who need help are, in fact, being helped. In those States which have plans, eligibility requirements and the types and extent of services provided, combine to sharply limit the number of those aided. (Eligibility requirements and benefits are considered in chs. III and IV.) The section which follows provides concrete evidence of the relatively few of our almost 18 million older Americans who receive any help from MAA.

2. NUMBER OF RECIPIENTS

The Bureau of Family Services of the Welfare Administration issues monthly reports which show the total number of MAA recipients for the latest month for which data are available. In August 1962 the Bureau reported a total of 108,939 recipients of medical assistance for the aged in the 26 jurisdictions reporting payments for that month. For the month of August 1963, 31 jurisdictions reported payments made in behalf of 148,467 older persons.

TABLE II.—*Number of recipients in jurisdictions making MAA payments, August 1963*

Jurisdiction	Number of recipients	Percent of all MAA recipients	Percent of aged in jurisdiction on MAA rolls
Total	148,467	100.0	1.27
New York	32,606	22.0	1.80
California	20,415	13.8	1.32
Massachusetts	23,300	15.7	3.96
Michigan	5,089	3.4	.75
Pennsylvania	6,629	4.5	.57
Washington	9,122	6.1	3.07
Connecticut	6,666	4.5	2.56
New Jersey	4,238	2.9	.69
Oregon	3,517	2.4	1.86
West Virginia	8,977	6.0	5.22
Utah	2,131	1.4	3.28
Maryland	8,046	5.4	3.28
Illinois	657	.4	.07
North Dakota	1,040	.7	1.79
Idaho	1,654	1.1	2.63
District of Columbia	498	.3	.67
Hawaii	587	.4	1.78
Oklahoma	893	.6	.34
Kentucky	5,233	3.5	1.74
Arkansas	2,299	1.5	1.13
Maine	356	.2	.33
Tennessee	1,281	.9	.40
Puerto Rico	1,663	1.1	1.28
South Carolina	458	.3	.29
Alabama	232	.2	.09
Louisiana	370	.2	.14
New Hampshire	205	.1	.29
Vermont	63	(1)	.14
Florida	25	(1)	
Virgin Islands	105	.1	3.50
Guam	112	.1	11.20
Wyoming	(2)		

[1] Less than 0.05 percent.
[2] No payments made in August.

The year-to-year increase in the number of recipients does not signify any particularly marked progress in the relative ability of MAA to reach older persons who need help. The number helped should be considered in relation to several factors:

A. Only 8 out of every 1,000 older Americans received any sort of help from the Kerr-Mills MAA program in August 1963. It was the hope of the Congress that all States would, ultimately, fully implement MAA. Such complete institution of MAA programs could, it was believed, provide potential protection to as many as 10 million aged persons.

The 1960 estimate of 10 million people who might need help was based upon a population of 16 million persons age 65 and over and would have to be increased today, as the aged population has enlarged to almost 18 million. While not every one of the medically indigent requires medical services each year, a very substantial proportion do. As many as one of every six aged persons requires hospitalization each year—and an even greater proportion require the services of physicians and need prescribed drugs.

B. There is a very heavy carryover of MAA recipients from month to month. Thus, the annual total of *different individuals* receiving MAA help cannot be obtained by adding or projecting monthly totals of MAA recipients. The fallacy involved in use of the latter method, in attempts to demonstrate vast numbers of people helped, is strikingly illustrated by preliminary data on MAA recipients now available for

fiscal 1962. Multiplication of the average monthly number of MAA recipients would indicate a total of 892,728 older persons aided during that year. However, as table III reveals, *only 217,797 different people received any help during those 12 months.*

TABLE III.—*Number of different recipients who received MAA care, by jurisdiction, fiscal year 1962* [1]

Jurisdiction	Average monthly number of recipients	Number of different recipients during year	Jurisdiction	Average monthly number of recipients	Number of different recipients during year
Total [1]	74,394	217,797	Michigan	4,649	13,585
			New Hampshire	25	120
Alabama	126	706	New York	27,791	69,900
Arkansas	820	3,836	North Dakota	650	1,237
California	10,624	18,572	Oklahoma	309	2,363
Connecticut	3,948	4,347	Pennsylvania	1,935	12,915
Hawaii	267	783	Puerto Rico	1,417	8,732
Idaho	1,068	2,441	South Carolina	441	3,217
Louisiana	211	1,465	Tennessee	282	1,921
Maine	265	1,470	Utah	332	956
Maryland	4,638	8,807	Washington	563	3,723
Massachusetts	18,557	30,133	West Virginia	6,685	26,568

[1] Data not yet available for Guam, Illinois, Kentucky, Oregon, and Virgin Islands.

C. As tables II and III show, the overwhelming majority of MAA recipients are concentrated in a few States. On whatever analytical basis employed—monthly or annual—the States of New York, California, and Massachusetts account for over one-half of all persons receiving MAA help. Those three States, alone, accounted for 52 percent of all MAA recipients in August, while their older populations represented only 38 percent of all persons aged 65 and over residing in States with MAA plans in operation and only 22 percent of all elderly citizens in the Nation.

Several facts combine to explain the predominant position of these three States in the Kerr-Mills program. They rank among the wealthiest States in the Nation, and are able, therefore, to generate the funds necessary to finance plans with eligibility requirements and benefits that are comparatively more liberal than those in most of the other States with MAA plans. Additionally, these are States which had relatively broad programs of medical aid for the indigent elderly in operation prior to enactment of Kerr-Mills. Implementation of MAA represented a much smaller step for these States than it did for most of the others. Finally, and significantly, they transferred in large part, responsibility for certain types of medical care—particularly long-term hospital and skilled nursing home care—from their old-age assistance (relief) programs to MAA. Along with the transfer of functions went many tens of thousands of older citizens who had previously been receiving the transferred benefits under the old-age assistance programs. And, additional tens of thousands who would have been eligible for OAA help in the absence of MAA, now go directly into the Kerr-Mills plans.

The policy discussed is not unique to the three States in the MAA program. It has been applied in other States as well, with any differences being only of degree.

A dramatic example of the impact of this policy of transferring responsibility for care from one program to another recently occurred in the State of Washington. That State reported a total of $187,559 paid in behalf of 1,176 recipients of MAA during the month of May 1963. For the month of June 1963, however, Washington reported total payments of $1,282,149 for care of 9,623 recipients of MAA. State officials advise that this tremendous increase in MAA payments and recipients was occasioned by the transfer of recipients of nursing home care under the old-age assistance program to Washington's MAA plan.

These transfers are of course totally inconsistent with the intent of the Congress when it enacted Kerr-Mills. A recent article analyzing the Kerr-Mills MAA program in Connecticut appeared in the August issue of the authoritative journal Hospital Progress. The authors, Albert W. Snoke, M.D., and Parnie S. Snoke, M.D., had this pertinent remark to make concerning the matter of transfer of assistance recipients to MAA:

> In this preliminary and tentative study of MAA in Connecticut, it is apparent that the program is an extension of an existing welfare program for health care of the needy aged. A large percentage of patients previously receiving assistance through OAA have been transferred to MAA. The caseload in Connecticut is steadily increasing.

The reasons for the action of these States are understandable. It is essentially a means of securing Federal money which would otherwise be unavailable to them. This procedure and the underlying motives are discussed, in greater detail, in the next chapter.

Table IV presents a comprehensive picture of the number of MAA applications received by the various States, and their disposition, from the inception of operations of the State plans through September 1962. Particular attention is called in the table to the 81,423 transfers from other programs. But, subtraction of the people transferred is only the first step in attempting to determine the number of persons to whom publicly financed medical assistance would have been unavailable if Kerr-Mills had not been enacted. The second step involves awareness of the many thousands, who, while they were never on the old-age assistance rolls, could qualify for help under the OAA relief program but who, instead, are now being placed directly into the Medical Assistance for the Aged program.

The Bureau of Family Services, in response to an inquiry, made the following reply:

> Of the 346,800 persons approved for MAA through September 1962, 81,400 were transferred from other public assistance programs and 265,400 were new cases. *Based on incomes only, about 213,000 of the 265,400 new cases would have been eligible for OAA.* [Emphasis supplied.]

TABLE IV.—*Medical assistance for the aged: Application and case turnover data from inception of programs through September 1962, by jurisdiction*

State	Month and year applications first reported	Cumulative number transferred from other programs through September 1962	Cumulative number of applications received through September 1962		Cumulative number of applications approved through September 1962		Cumulative number of applications denied or otherwise disposed of	Cumulative number of cases closed through September 1962	Applications approved as a percent of applications disposed of		Cases transferred as a percent of cases authorized	Cases closed as a percent of total applications approved
			Total	Excluding transfers	Total	Excluding transfers			Total	Excluding transfers		
Total		81,423	445,904	364,481	346,847	265,424	81,454	142,940	81.0	76.5	23.5	41.2
Alabama	February 1962	1	1,882	1,881	1,255	1,254	555	331	69.3	69.3	0	26.4
Arkansas	September 1961	0	8,949	8,949	7,209	7,209	1,585	1,397	82.0	82.0	0	19.4
California	December 1961	17,972	31,666	13,694	23,523	5,551	5,997	23	79.7	48.1	76.4	.1
Connecticut	April 1962	4,346	7,264	2,918	5,348	1,002	1,181	777	81.9	45.9	81.3	14.5
Guam	June 1962	0	153	153	61	61	0	6	100.0	100.0	0	9.8
Hawaii	July 1961	222	1,162	940	868	646	269	259	76.3	70.6	25.6	29.8
Idaho	do	1,350	3,530	2,180	3,064	1,714	384	704	88.9	81.7	44.1	23.0
Illinois	August 1961	0	8,486	8,486	4,508	4,508	3,049	1,260	59.7	59.7	0	28.0
Kentucky	March 1961	195	12,100	11,905	10,309	10,114	1,007	1,721	91.1	90.9	1.9	16.7
Louisiana	December 1961	0	3,471	3,471	2,065	2,065	1,327	1,944	60.9	60.9	0	94.1
Maine	October 1961	0	3,212	3,212	2,841	2,841	371	701	88.4	88.4	0	24.7
Maryland	June 1961	0	19,134	19,134	14,698	14,698	4,261	3,578	77.5	77.5	0	24.3
Massachusetts	October 1960	22,553	51,050	28,497	40,849	18,296	8,631	17,986	82.6	67.9	55.2	44.0
Michigan	do	3,934	31,422	27,488	24,332	20,398	6,490	15,929	78.9	75.9	16.2	65.5
New Hampshire	September 1961	0	432	432	318	318	89	74	78.1	78.1	0	23.3
New York	April 1961	28,677	125,842	97,165	99,498	70,821	23,537	64,756	80.9	75.1	28.8	65.1
North Dakota	July 1961	1,053	1,999	946	1,697	644	226	610	88.2	74.0	62.1	35.9
Oklahoma	December 1960	0	6,724	6,724	5,243	5,243	1,236	2,905	80.9	80.9	0	55.4
Oregon	October 1961	460	8,016	7,556	5,642	5,182	2,324	900	70.8	69.0	8.2	16.0
Pennsylvania	January 1962	88	35,071	34,983	20,849	20,761	10,257	(1)	67.0	66.9	.4	(2)
Puerto Rico	do	0	11,972	11,972	10,729	10,729	44	3,860	99.6	99.6	0	36.0
South Carolina	July 1961	0	9,955	9,955	6,700	6,700	2,834	1,115	70.3	70.3	0	16.6
Tennessee	do	0	9,944	9,944	7,235	7,235	2,217	865	76.5	76.5	0	12.0
Utah	do	508	1,601	1,093	1,254	746	327	376	79.3	69.5	40.5	30.0
Vermont	July 1962	2	231	229	157	155	58	15	73.0	72.8	1.3	9.6
Virgin Islands	February 1961	1	624	623	594	593	24	83	96.1	96.1	.2	14.0
Washington	October 1960	61	9,135	9,074	6,537	6,476	2,536	(1)	72.0	71.9	.9	(2)
West Virginia	do	0	40,877	40,877	39,464	39,464	638	20,765	98.4	98.4	0	52.6

[1] Data not available. Not computed; data not available.

The figure is startling—even after allowance for the fact that it does not exclude those older persons who might be ineligible for OAA by virtue of possession of assets above the permissible limits or because they do not meet other eligibility requirements. Even the most conservative of critics would have to concede that, through September 1962, probably well over one-half of all applications approved for MAA were submitted in behalf of older persons previously receiving or eligible for medical aid under a public program other than Kerr-Mills.

A thoroughgoing analysis of federally aided expenditures for medical care of the aged in the United States was recently released by the New York State Department of Social Welfare.[4] Commenting on the failure of the OAA and MAA programs to reach the elderly in need of assistance, the report stated:

> It was certainly not the intention of the Congress in passing the Kerr-Mills bill to have the States use it as a vehicle for the States to reduce their appropriations for the sick aged. If this were the intention, the Congress could merely have enriched the Federal grant-in-aid formula for OAA and not establish a second program for the aged. *The purpose of the sponsors of the Kerr-Mills Act was to inaugurate a second program for the aged which would aid aged persons not eligible for OAA to obtain needed medical care.* A successful program would have resulted in increasing the proportion of aged persons on public assistance from about 14 percent to about 20 percent. This proportion would still be lower than the 22.4 percent of the aged population who received care under OAA in December 1950. *Today, the percentage of the aged aided under the two programs, OAA and MAA, is about 13 percent and in a declining trend. MAA's primary objective, helping a large proportion of low-income aged persons obtain medical care, has not been realized. Adoption of MAA programs by States not presently having this program would not improve the situation any.*

Documenting this indictment of the adequacy of the two welfare programs—OAA and MAA—the New York State report commented:

> The inauguration of the MAA program under the public assistance titles of the Social Security Act on October 1, 1960, did not result in adding aged persons to the public assistance rolls. The number of recipients under the two programs for the aged, OAA and MAA, was in December 1962, 2,336,000, 13.2 percent of the aged population. In December 1960, the number was 2,346,000, 13.8 percent of the aged in that year. For December of earlier years the corresponding figures were:
>
> 1950 (OAA only): 2,786,000 persons; 22.4 percent of the aged population.
> 1954 (OAA only): 2,565,000 persons; 18.3 percent of the aged population.
> 1956 (OAA only): 2,514,000 persons; 17.3 percent of the aged population.
> 1958 (OAA only): 2,452,000 persons; 15.9 percent of the aged population.
> 1960 (OAA and MAA): 2,346,000 persons; 13.8 percent of the aged population.
> 1962 (OAA and MAA): 2,336,000 persons; 13.2 percent of the aged population.
>
> The decrease between December 1960 and December 1962 shown above is an understatement of the extent of the decrease between the two years. The December 1962 figures included not only transfers from the OAA program but transfers of aged persons who, in 1960, were on other public welfare programs such as aid to the blind, aid to the disabled, general assistance, and medical indigents. The decline has continued since December 1962. In March 1963, the number of aged on the rolls was 2,332,000 while the number of aged in the population had increased some 90,000.

We wish to make it quite clear, at this point, that we are not opposed to the provision of medical benefits to older people—under

[4] "Medical Care Expenditures for the Aged in the United States Under the Federally Aided Public Assistance Programs, January-March 1963," New York State Department of Social Welfare, Office of Medical Economics, Aug. 15, 1963.

whatever program such care may be provided. We believe, however, that the transfer of many thousands of recipients of old-age assistance to the MAA program, as well as the fact that many additional thousands of MAA recipients would have been eligible for help in the absence of MAA, have inflated and distorted, in very large measure, the true total of those older persons to whom benefits would have been unavailable in the absence of a Kerr-Mills program. The latter, of course, represent the people for whom MAA was intended.

The problems we have just discussed are evidence only of possible inadequacies in the financing of medical care under old-age assistance—that is, for people on relief. They certainly do not constitute evidence of the adequacy of Kerr-Mills MAA.

3. RESPONSIBILITY FOR PROMOTING MAA

The charge has often been made that a major reason for nonimplementation of Kerr-Mills MAA by States and the failings in existing programs is a lack of enthusiasm and cooperation on the part of the Department of Health, Education, and Welfare.

The Department clearly has responsibility to assist the States in implementing the enabling legislation. All evidence available indicates that the Department has accepted and fulfilled that responsibility to the extent possible. The shortcomings of the Kerr-Mills program of Medical Assistance for the Aged are substantive and cannot be overcome by zealous promotion.

One of the methods employed by the Department to facilitate implementation and administration of MAA plans, is a series of State letters which are regularly forwarded to State agencies administering public assistance programs. Appendix A consists of two of the earliest letters to the States, as well as a brochure prepared by the Bureau of Public Assistance (now Bureau of Family Services) and offered to the States for mass distribution. These items all date back to the inception of Kerr-Mills and typify the strong and legitimate encouragement supplied in support of the MAA program. The appendix also includes a summary of actions taken by the Department to assist State implementation of Kerr-Mills.

CHAPTER II

COST OF THE MEDICAL ASSISTANCE FOR THE AGED PROGRAM

Evaluation of MAA expenditures and forecasts of prospective expenditures is a somewhat clouded task. Determination of the exact amount of "new" money expended under MAA is complicated by the transfer of many tens of thousands of aged persons from OAA medical care programs to MAA, as well as by the transfer of funds from other programs to MAA in order to take advantage of more favorable matching provisions. And, any computation of "new" money for "new" people would have to be decreased by the amounts expended in behalf of recipients, who, while not previously enrolled in OAA, would have been eligible for some help under OAA or other relief program had Kerr-Mills not been enacted.

These considerations should be borne in mind in evaluating table V, which indicates, by State, total MAA expenditures of $372 million from the inception of Kerr-Mills through December 1962. The Federal share in these payments was $189 million—some 51 percent of the total.

State and Federal MAA payments in August 1963—almost 3 years after passage of Kerr-Mills—total $29,042,000. (See table VI.) This is at an annual rate of about $350 million.

TABLE V.—*Medical assistance for the aged: Total payments and Federal share of payments for medical or remedial care, by jurisdiction, calendar year 1962, and from inception of program through December 1962*

[In thousands]

Jurisdiction	Calendar year 1962		From inception of program through December 1962	
	Total	Federal share	Total	Federal share
Total	[1] $252,502	$128,106	[2] $372,560	$188,689
Alabama	393	310	393	310
Arkansas	810	648	863	690
California	46,046	23,023	46,046	23,023
Connecticut	[1] 6,781	3,128	[2] 6,781	3,128
Guam	11	6	11	6
Hawaii	1,195	635	1,417	753
Idaho	2,090	1,385	2,878	1,907
Illinois	2,414	1,207	2,430	1,215
Kentucky	535	405	620	469
Louisiana	793	575	794	576
Maine	750	499	750	499
Maryland	2,519	1,259	3,183	1,591
Massachusetts	[1] 44,274	21,555	[2] 87,737	42,545
Michigan	18,726	9,363	32,781	16,390
New Hampshire	41	24	41	24
New York	[1] 103,322	51,444	[2] 157,573	78,569
North Dakota	[1] 1,986	1,421	[2] 2,501	1,785
Oklahoma	1,116	743	1,679	1,119
Oregon	524	268	524	268
Pennsylvania	10,615	5,304	10,615	5,304
Puerto Rico	530	265	611	305
South Carolina	1,023	818	1,218	974
Tennessee	413	314	441	336
Utah	1,265	804	1,291	821
Vermont	63	42	63	42
Virgin Islands	26	13	36	18
Washington	1,632	813	2,999	1,567
West Virginia	2,609	1,835	6,283	4,453

[1] Includes money payments to recipients not subject to Federal matching as follows: Total, $1,672,000; Connecticut, $50,000; Massachusetts, $1,163,000; New York, $435,000; and North Dakota, $25,000.

[2] Includes money payments to recipients not subject to Federal matching as follows: Total, $3,169,000; Connecticut, $50,000; Massachusetts, $2,647,000; New York, $435,000; and North Dakota, $37,000.

TABLE VI.—*Medical assistance for the aged (MAA): Vendor payments by State and Federal share, August 1963*

Jurisdiction	Total payments		Federal share of payments		
	Amount	Percent of national total	Matching percent	Amount	Percent of national total
Total	[1] $29,642,507	100.0		$15,141,258	100.0
New York [1]	10,141,685	34.2	50.00	5,047,180	33.3
California	5,605,066	18.9	50.00	2,802,533	18.5
Massachusetts [1]	4,007,719	13.5	50.00	1,955,000	12.9
Michigan	1,772,684	6.0	50.00	886,342	5.9
Pennsylvania	1,553,775	5.2	50.00	776,888	5.1
Washington	1,289,647	4.4	50.00	644,824	4.3
Connecticut [1]	1,074,437	3.6	50.00	536,936	3.5
New Jersey [1]	741,637	2.5	50.00	365,128	2.4
Oregon	474,413	1.6	50.00	237,206	1.6
West Virginia	370,586	1.3	71.76	265,933	1.8
Utah	322,652	1.1	62.28	200,948	1.3
Maryland	295,328	1.0	50.00	147,664	1.0
Illinois	287,712	1.0	50.00	143,856	1.0
North Dakota [1]	222,070	.7	73.03	160,540	1.1
Idaho	215,566	.7	67.43	145,356	1.0
District of Columbia	175,389	.6	50.00	87,694	.6
Hawaii	163,734	.6	50.00	81,867	.5
Oklahoma	147,404	.5	65.65	96,771	.6
Kentucky	146,155	.5	75.27	110,011	.7
Arkansas	133,678	.5	80.00	106,942	.7
Maine	86,256	.3	65.65	56,627	.4
Tennessee	81,461	.3	75.53	61,527	.4
Puerto Rico	77,128	.3	50.00	38,564	.3
South Carolina	66,776	.2	80.00	53,421	.4
Alabama	59,890	.2	78.29	46,888	.3
Louisiana	57,121	.2	73.46	41,961	.3
New Hampshire	41,602	.1	56.38	23,455	.2
Vermont	20,990	.1	64.75	13,591	.1
Florida	5,914	[2]	60.69	3,589	[2]
Virgin Islands	3,409	[2]	50.00	1,704	[2]
Guam	623	[2]	50.00	312	[2]
Wyoming	[3]		50.00		

[1] Includes money payments to recipients not subject to Federal matching: Connecticut, $564; Massachusetts, $97,720; New Jersey, $11,382; New York, $47,326; North Dakota, $2,242.
[2] Less than 0.05 percent.
[3] No payments made in August.

Estimates of future MAA expenditures are complicated by the lack of certainty with regard to the number of States which will ultimately implement Kerr-Mills—and, of even greater significance, whether implementation will be meaningful rather than token. Additionally, it is impossible to determine how many States may further restrict their programs in attempts to control or reduce expenditures, or just how many States may liberalize their programs. As the States' share of funds for MAA plans are usually dependent upon periodic appropriations by legislatures, with all the uncertainties inherent in that procedure, forecasting suffers a further handicap. Nonetheless, some reasonable estimates are possible.

NEGATIVE ASPECTS OF KERR-MILLS EXPENDITURES

Based upon estimates of expenditures submitted by the various jurisdictions to the Bureau of Family Services, 35 jurisdictions expect to make total MAA payments of $343 million in fiscal year 1964. The Federal share of this total is estimated at $179 million.

Unquestionably, the Kerr-Mills program has enabled States to inject millions of "new" dollars into their medical care plans. Three significant negative factors, however, combine to reduce the extent to which MAA funds are "new" funds and the extent to which the "new" funds are most beneficially expended:

(a) *Use of the Kerr-Mills MAA program as a means of financing benefits for people who were eligible for some help under Old-Age Assistance program or other relief programs*

The Federal Government will match vendor payments under MAA without limitation as to maximum amount, while matching payments under OAA—both "Federal percentage," and "Federal medical percentage"—are available up to specified maximums only. For example, a State whose "Federal percentage" and "Federal medical percentage" in the matching formulas (see app. B) are both at the 50-percent level, and whose average OAA monthly assistance payment is $80, including vendor payments of $15 for medical care, would receive $51.50 per month in Federal funds for each OAA recipient. If its nursing home payments under OAA are $200 monthly per person, the Federal share of this cost is $51.50. But, if the nursing home patient is transferred to MAA the Federal grant then becomes $100 instead of $51.50. Thus, instead of the State spending $148.50 of its funds for this nursing home care, it will have to spend only $100 of its own funds, with the Federal Government paying the difference.

We have previously noted the wholesale transfer of recipients of OAA, whose primary need is for medical care, from the relief program to MAA. The foregoing paragraph explains the motivation for the transfer—more Federal money.

Somewhat unusual confirmation of this attitude of regarding Kerr-Mills as a prime device for securing new Federal funds for an "old" program is contained in a very recent report to the Congress of the Comptroller General.[1] The report takes the government of the District of Columbia to task for delay in implementation of MAA. But, the prime fault of the District, according to this study, was *not* that its delay prevented medical care from being made available to a new category of recipients—the medically indigent—*but* that the District had not taken timely advantage of an opportunity to secure millions of Federal dollars for its existing program. In the words of the Comptroller General:

> Our review disclosed that, *at the time the legislation was enacted, low-income aged residents of the District of Columbia were already being provided the type of basic care and services contemplated under the medical assistance for the aged program.* However, to become eligible for Federal grants, the District needed to obtain legislative authority to change certain of its residency requirements. We found that the District delayed seeking necessary legislative authority and did not adequately prepare for participation in the program. We estimate that as a result, the District did not receive about $1,800,000 in available Federal grants. [Emphasis supplied.]

There is nothing illegal about States using MAA to increase Federal grants to them. However, it was clearly not the intent of the Congress when it authorized MAA that new Federal funds be used to the extent they have been in relieving the States and communities of payments which they were already making. The Congress intended that this help be extended to an entirely new group of citizens—not those already on relief or eligible for it. Congress was assuming a new responsibility—not relieving the States of an existing burden.

[1] Report to the Congress of the United States on "Delay in Development and Implementation of Medical Assistance for the Aged Program, District of Columbia Government," July 1963.

(*b*) *The more favorable Federal matching available under MAA has diverted State funds which might otherwise be employed in reducing or eliminating the presently "unmet needs" of the most indigent elderly—those people on relief*

Consideration of the Kerr-Mills Act as "a sensible workable solution" to the broad and complex problem of provision of care for the medically needy aged, implies that all States have the financial capacity prerequisite to establishment of meaningful MAA plans. Such thinking, however, overlooks the fact that many States are unable—even with substantial help from the Federal Government—to adequately finance the health needs or even the basic living requirements of their most indigent aged. In the context of this fact, those States which have implemented MAA and have not as yet adequately provided for their people on relief, have built a shaky superstructure upon a weak foundation. The urgency to construct a facade has bypassed the necessity of considering "first things first."

Inadequate attention has been paid to the limited financial resources of many States, and to the competing claims of other needs—education, roads, housing, etc.—on those limited resources.

A State that cannot *now* provide for even the most *basic* needs of its OAA recipients—with "basic" defined according to the State's own standards and disregarding special needs such as medical care—is unlikely to reach very far beyond its OAA rolls to encompass people who are medically indigent.

The recent report to the Senate of the Special Committee on Aging [2] highlighted this problem:

> The inability of the States to allocate adequate funds to Kerr-Mills is not surprising in view of the fact that most States cannot even provide appropriations adequate to meet the basic needs of their admittedly completely indigent citizens. In 1960, most of the States failed to meet their own standards of needs for the aged on their old-age assistance rolls—people on relief. *Obviously, a State that cannot adequately provide basic necessities for its most disadvantaged people cannot be expected to give priority to a new medical assistance program for people who are better off.* [Emphasis supplied.]

Recipients of old-age assistance, as a group, are much older than the general population aged 65 and over. (The median age of all persons receiving OAA in 1960 was 76.4 years as compared with 72.1 for all persons 65 and over.) They have especially heavy medical needs. This is partly due to their advanced ages—but it is also due to the fact that many are on the OAA rolls as a result of illness with continuing need for medical care.

Despite this greater need, 27 jurisdictions are providing less than $15 a month in vendor medical payments per OAA recipient.[3] There are some 1,430,000 OAA recipients in these 27 jurisdictions. Even after subtraction of 320,000 OAA recipients in the States of California, Idaho, and Michigan where average vendor payments were lowered by virtue of the transfer of high-cost nursing home cases to MAA, the remaining 1,110,000 in the 27 jurisdictions represent one-half of all OAA recipients in the Nation.

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[2] "Developments in Aging, 1959 to 1963," S. Rept. 8, Feb. 8, 1963. p. 25.

[3] Source: Bureau of Family Services. Data for February 1963. The 27 jurisdictions are: Alabama, Alaska, Arizona, Arkansas, California, Delaware, Georgia, Guam, Idaho, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Missouri, Montana, North Carolina, Pennsylvania, Puerto Rico, South Carolina, South Dakota, Tennessee, Texas, Utah, Virgin Islands, West Virginia, and Wyoming.

Average monthly vendor payments for medical care:	*Number of jurisdictions*
Total	54
Under $5	4
$5 to $9.99	14
$10 to $14.99	9
$15 to $19.99	10
$20 to $24.99	4
$25 and over	13

If the levels of payment for vendor medical care were to be increased to $15 a month per recipient—the maximum amount of vendor payments subject to Federal sharing under OAA—the total vendor payments in the 27 jurisdictions would be approximately $21,500,000 monthly, 71 percent higher than the $12,600,000 expended in February 1963.[4]

The $15 base ($180 a year) does not seem an unreasonable minimum for the older, sicker than average aged on OAA, in view of the fact that the average medical costs for persons 65 and over were estimated at $315 for 1961. The $15 per month is less than three-fifths of the average in 1961—the current average would be higher.

There would appear little doubt that a State's primary obligation is to provide more adequately for its OAA recipients before moving into new areas of need. It would seem logical that they should give priority to closing the gaps in their OAA programs before attempting to cope with new areas of need.

(c) The superior ability of the wealthier States to generate matching funds has resulted in a marked uneven and inequitable distribution of MAA money among the several States—a result contrary to congressional intent

Unlike a social security-financed program of hospital and related benefits, which would assure everyone 65 and over of the same benefits wherever he might live in the United States, assuming that a medically indigent individual resides in a State that has an MAA program, his ability to qualify for aid, and the amount of assistance available, will depend upon which State he lives in rather than upon the extent of his health needs or the cost of the necessary care.

Payment of Federal matching funds to a State depends upon whether that State has a program and how extensive its program is. As a result of the open-ended formula for Federal matching in the MAA program, the wealthier States most able to generate funds toward their portion of the cost of a comprehensive program with liberal eligibility requirements are able to secure greater amounts in Federal matching funds. The relatively greater ability of the wealthier States to raise money despite the advantage offered to the lower income States in the matching formula, means that the aged in the lower income States are placed at a disadvantage due to the limited abilities of their States to raise matching funds.

The formulas for Federal participation in public assistance grants are predicated upon the basic assumption that the States with the lowest per capita income need the greatest Federal help in financing their programs. The less wealthy States would, thus, if they provided

[4] Some States provide medical care to their recipients of OAA outside of the vendor payment mechanism. Such provision may include a combination of money and vendor payments or care provided in governmental facilities. In the main, however, evaluation of State programs predicated upon average vendor payments per OAA recipient constitutes a reasonable index of the extent to which medical needs are being met.

the same scope of medical care under Kerr-Mills as do the wealthier States, receive more money per recipient from the Federal Government. The fact that, generally speaking, the poorest States spend less per needy person (including Federal funds) for their public assistance recipients suggests significant limitations in ability to provide additional State funds for matching purposes under MAA.

Therefore, States with the poorest provisions for medical care of the totally and medically indigent would seem to be those least able to assume the costs involved if they were to attempt to provide the level of medical care available to OAA and MAA recipients in other States.

Conversely, as we have noted, States with fairly broad public assistance medical care provisions and liberal means tests for OAA already in effect, needed to take relatively little further action to provide medical care benefits under MAA. But, that "relatively little further action" represented a financial windfall for the wealthier States.

We have illustrated the financial advantage accruing to a State by virtue of transfer of a nursing home patient, whose care cost $200 a month, from OAA to MAA. It will be recalled that this simple action meant that the State would receive $100 in Federal money under MAA rather than the $51.50 it would get under OAA. The consequent transfer of tens of thousands of OAA recipients, particularly in the wealthier States, from OAA to MAA has resulted, predictably, in a few States receiving the overwhelming proportion of Federal matching funds. And, as the situation now stands, these States will continue to receive a disproportionate share of Federal money, at least in relation to the percentage of the Nation's elderly who live in those few States.

Tables V and VI (see pp. 19-20) indicate the dimensions of the imbalance in the distribution of MAA funds. Five States—California, Massachusetts, Michigan, New York, and Pennsylvania—received 88 percent of the $189 million in Federal funds expended from the inception of the program through December 1962. However, only 32 percent of the older population of the Nation resides in those States. (Because they are relatively high income States, they can be expected to have an even smaller proportion of their aged population who are needy.) Only 10 percent of the Nation's aged live in the State of New York. New York, however, received 42 percent of the $189 million.

The five States mentioned above each receive only the minimum Federal matching grant—50 percent—in contrast to the maximum 80-percent Federal help for which some of the less wealthy States qualify. The fact that these States secure the lion's share of Federal money, despite being at the bottom of the matching formula, further highlights the far greater fiscal ability of the richer States to utilize MAA grants.

The disproportionate sharing of MAA payments may well continue over the long run. In August 1963, California, Massachusetts, Michigan, New York, and Pennsylvania accounted for 76 percent of the Federal funds allocated to MAA.

The disparity, noted above, should lessen somewhat with full-scale implementation of MAA programs in other large States. Nonetheless, the basic imbalance and disproportionate participation in MAA will continue to be striking as between those States with high and those with lower per capita incomes.

(The five States we have discussed are expected to receive 72 percent of all Federal MAA funds allocated during fiscal 1964.)

While the intent of the Kerr-Mills formula was to increase the relative flow of Federal funds to the low per capita income States, the effect in the MAA program has been virtually the opposite. Those States which cannot afford to implement MAA, or which can only implement it nominally, are the low-income States. The real flow of funds is to the wealthier States. The Federal share comes from general revenues to which all States, including those which cannot afford Kerr-Mills, have contributed. The 12 States with the lowest per capita incomes in the Nation contribute 10 percent of total Federal taxes.[5] In August 1963 the total Federal return in MAA matching funds to those of the 12 States which participate in MAA amounted to 5 percent of total Federal MAA grants. Thus, Mississippi, which contributes one-half of 1 percent of Federal taxes, received no Federal MAA money in August, while New York, which pays some 13½ percent of taxes, received 33 percent of the total Federal grants for that month.

ADMINISTRATIVE COSTS OF MAA

Complex administration is expensive

The costs of administering the MAA and OAA health care programs are a significant drain upon the limited resources of the States. These costs constitute a large portion of total expenditures for almost any type of medical assistance other than long-term hospital or nursing home care.

Under a public assistance health care program such as MAA, a complete "workup" must be made for each applicant for assistance. Eligibility has to be determined by examination of resources, including such difficult evaluative factors as the value of assets and, in almost half of the programs, the ability of relatives to contribute. Redeterminations of eligibility and field investigations to determine the accuracy of the applicants' statements add to administrative expense. The cost of such investigations is quite large in relation to the actual payments to physicians, or for prescribed drugs, and even for some hospital bills.

Total administrative costs for MAA during calendar 1962, excluding the costs of determining eligibility for recipients transferred from other programs, were $15,700,000, or 6.2 percent of total medical care vendor payments. Among the States, Tennessee had the highest ratio of administrative costs to vendor payments, 59.3 percent. Four other States had ratios of over 25 percent. In other words, it cost Tennessee 59 cents to pay out $1 in benefits, with the other four States each spending more than 25 cents for every $1 they were able to pay to medical vendors.

As table VII indicates, the average administrative cost for each applicant approved for MAA during calendar 1962 was $70. Five States had average administrative costs in excess of $100, but none of these were in States where administrative costs represented a particularly high percent of vendor payments. In these States, the moderate administrative costs in relation to total payments resulted

[5] Based upon fiscal year 1962. As calculated by Tax Foundation, Inc., and published in "Facts and Figures on Government Finance."

TABLE VII.—*MAA: Administration costs in relation to total vendor payments, and applicants, by jurisdiction, calendar year 1962*

[Expenditures in thousands]

Jurisdiction	Payments began	Expenditures			Applicants			Average administrative costs per case [2]	
		Vendor payments	Administration [1]	Administration as percent of vendor	Total	Assistance granted		Total applications	Assistance granted
						Number	Percent of total		
Total		$250,830	$15,652	6.2	297,555	223,875	75.2	$52.60	$69.91
Alabama	February 1962	393	42	10.7	2,425	1,691	69.7	17.32	24.84
Arkansas	October 1961	810	102	12.6	7,577	6,226	82.2	13.46	16.38
California	January 1962	46,046	2,933	6.4	34,912	27,147	77.8	84.01	108.06
Connecticut	May 1962	6,731	458	6.8	3,806	2,175	57.1	120.34	210.57
Guam	June 1962	11	3	27.3	139	76	54.7	21.58	39.47
Hawaii	July 1961	1,195	41	3.4	777	577	74.3	52.77	71.06
Idaho	August 1961	2,090	156	7.5	2,191	1,862	85.0	71.20	83.78
Illinois	November 1961	2,414	93	3.9	8,487	5,275	62.2	10.96	17.63
Kentucky	April 1961	535	156	29.2	7,561	6,760	89.4	20.63	23.08
Louisiana	December 1961	793	229	28.9	4,332	2,716	62.7	52.86	84.32
Maine	January 1962	750	17	2.3	4,729	4,142	87.6	3.59	4.10
Maryland	June 1961	2,519	119	4.7	11,831	9,366	79.2	10.06	12.71
Massachusetts	November 1960	43,111	2,352	5.5	20,763	15,586	75.1	113.28	150.90
Michigan	November 1960	18,726	451	2.4	15,957	12,689	79.5	28.26	35.56
New Hampshire	December 1961	41	2	4.9	543	452	83.2	3.63	4.42
New York	April 1961	102,887	6,839	6.6	72,176	53,047	73.5	94.75	128.92
North Dakota	August 1961	1,961	175	8.9	999	832	83.3	175.18	210.34
Oklahoma	December 1960	1,116	39	3.5	4,869	3,997	82.1	8.01	9.76
Oregon	January 1962	524	144	27.5	4,747	3,337	70.3	30.33	43.15
Pennsylvania	February 1962	10,615	108	1.0	40,596	27,783	68.4	2.66	3.89
Puerto Rico	January 1961	530	11	2.1	14,687	12,796	87.1	.75	.86
South Carolina	August 1961	1,023	258	25.2	7,599	5,361	70.5	33.95	48.13
Tennessee	do	413	245	59.3	8,739	6,757	77.3	28.04	36.26
Utah	September 1961	1,265	62	4.9	2,213	1,905	86.1	28.02	32.55
Vermont	October 1962	63	15	23.8	478	340	71.1	31.38	44.12
Virgin Islands	May 1961	26	17	65.4	244	230	94.3	69.67	73.91
Washington	November 1960	1,632	69	4.2	5,633	3,809	67.6	12.25	18.11
West Virginia	do	2,609	516	19.8	8,547	6,941	81.2	60.37	74.36

[1] Includes costs of continuing cases on rolls; excludes costs of determining eligibility of cases transferred from other programs.

[2] Based on applications received during year rather than number of cases for which assistance was actually provided (latter data unavailable).

from high average assistance costs. On the other hand, there were three States where the average administrative cost per case was under $5—a cost quite low even for processing of an application form—suggesting that the method of accounting for costs produced an understatement of administrative expenses in some places.

As has been noted in previous reports, the more restricted the eligibility requirements and the more limited the benefits, the greater the relative administrative expense, because, along with generally less adequate administrative organizations, extremely careful screening out of applicants is required under such circumstances. Generally speaking, those States with the most restrictive programs—presumably the best they can afford—are confronted with the highest costs of administration in relation to the dollars going for actual medical care.

The Federal Government pays only 50 percent of the costs of administration, while it may pay as much as 80 percent of the dollars going for actual medical care. Thus, only a relatively small portion of a State's funds may go for medical care while a substantially greater amount may have to be allocated to administrative costs.

Unquestionably, in "means test medicine," too much money goes for the "means test" and not enough for the "medicine." In contrast to this, a social security-financed program would not spend millions of dollars investigating income and assets. The administrative expenses of such a program, estimated at 3 percent, would relate mainly to the procedure for paying benefits and not to the determination of eligibility.

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CHAPTER III

THE MEANS TEST—LIMITATIONS AND CONDITIONS AFFECTING ELIGIBILITY FOR KERR-MILLS MAA

To secure whatever medical services may be provided, the applicant for MAA must shroud himself in the welfare cloak. He must present a case proving, in essence, that he cannot take care of himself. He must document the insufficiency of his resources by stating, precisely, the amount and source of his income, and the value of each asset. In many States, similar statements are demanded of his relatives. These statements are then, of course, subject to extensive investigation. These investigative and processing procedures take time, often creating a substantial delay between the onset of need and authorization of aid. Finally, his State may be one of those which ultimately recover the cost of the MAA services provided by means of liens, extending to his home and collectible after death.

From the inception of Kerr-Mills, the question as to whether the MAA program required submission to a "degrading means test" or taking of a "pauper's oath" has been one of great concern and dispute.

Unquestionably, Kerr-Mills MAA was conceived of as a liberalization of public assistance medical care, designed to reach beyond the group of those eligible under old-age assistance, so as to encompass those persons with sufficient resources for their usual needs but not enough for medical costs. Each State, may, however, establish its own tests of eligibility for use in identifying individuals "whose income and resources are insufficient to meet the costs of necessary medical services."

While Kerr-Mills MAA clearly sought to distinguish the "medically indigent" from the "indigent," the means test, nonetheless, is an element common to the determination of both classes of indigency.

Undergoing a means test is basic to the determination of eligibility under any public assistance program. After a lifetime of independence and thrift, submission to the humiliation of a test of need is a painful experience for an aged person to accept—particularly when he is under the emotion and stress which accompany serious illness.

A report received on a prospective MAA applicant in Michigan illustrates the nature of the problem:

> Mrs. A and her son called at the Bureau office on February 7, 1963 to apply for MAA for Mr. A who was a patient at a local hospital.
>
> It was revealed that Mr. and Mrs. A owned their home free and clear and had bonds valued at $1,350. Their income consisted of $85.10 per month social security for Mr. A, and Mrs. A had part-time employment earning about $80 per month. Mr. and Mrs. A did not have hospital insurance.
>
> A caseworker explained the MAA program. Mrs. A said that she would like to discuss the matter with her husband and would return to the Bureau later. The next day a phone call was received from Mr. A requesting that the MAA application be withdrawn, and he also stated that they would pay the doctor bill themselves.

Here is an individual who would have, based upon the above data, and assuming no relative would have been required to assist, qualified for MAA in Michigan. But, rather than accept public assistance, it would appear, Mr. A preferred to pay for the necessary care out of his limited assets and income. These assets, it should be noted, are irreplaceable.

The staff report of last year included excerpts from a speech delivered to the American Medical Association by Dr. C. H. Peters, councilor of the Sixth District Medical Society (inserted in the Congressional Record, Apr. 11, 1962, pp. A2777–A2778), which underline the major problems in the usage of means tests in MAA programs. These comments are equally pertinent now:

> The "means test" is a second argument our opponents repeatedly throw at us. This is a more difficult, and politically a more formidable objection. It is said that this is one of the reasons that more individuals have not availed themselves of this program. The stigma of failure, of going on relief, often creates deep-rooted emotional bias on the part of the conscientious old individual. We have attempted to counter this feeling and argument by logic of one type or another. But logic frequently fails to sway individuals as all of you know from daily application in the practice of medicine.
>
> Before the public attitude can be changed, some members of the medical profession may have to change their own attitude.
>
> If the doctor himself looks down on assistance medical care, and upon the people who receive it, the public cannot be expected to accept this as anything but last-ditch aid.
>
> The AMA survey shows that in many States MAA is being considered as "just another welfare program," an OAA medical care program for a slightly higher income level. The applicant must go through the same routines, the same type of tests, the same type of investigations, and he receives his care through the same channels as the OAA recipient.
>
> Too stringent a means test can force the applicants to pauperize themselves past the chance of recovery before they can obtain aid. Rigid administrative methods developed to deal with the long-term needy can discourage applications for help. Lack of differentiation between the totally needy and the medically needy, and the way care is provided, can be so humiliating that many will not apply, except as a course of desperation, and again be unable to regain independence once the medical crisis has passed.

It should be noted that the applicant is not finished with means tests when he is initially judged eligible. Eligibility in continuing cases may be redetermined (at additional administrative cost) either within 1 year of the earlier certification of eligibility or each time care is required. And those States which apply more inflexible tests of eligibility under MAA than they do under OAA (see p. 31) have not achieved the purpose of the Kerr-Mills legislation.

Any program which makes eligibility for benefits contingent upon proof of nonexistent or limited income and assets uses a means test. If the objective of a public program designed to assist with the expenses accompanying illness is the preservation of the financial independence of older persons, then any program employing means tests—such as MAA—cannot achieve that goal. For, such programs afford some help *only* after the older individual has depleted his irreplaceable assets to the point of semidependency or total dependency. By comparison with this almost fatal flaw, the benefits of a social security-financed program, such as the King-Anderson proposal, would be immediately available to the older person without investigation of his financial status to determine whether his income or assets fell within specified limits. Thus, the older individual in need of hospital care would have that care paid for, irrespective of the fact that he

might have $5,000 in the bank. By protecting that "nest egg," the older citizen then has that money available to supplement his usually limited income in meeting his regular living expenses. Success in the preservation of that "nest egg" is very often the decisive factor in the ability of the older citizen to continue independent living. It is impossible to divorce consideration of how the aged person will manage after he is well from consideration of when and what benefits are available to him during illness.

FAMILY RESPONSIBILITY LAWS

An aspect of the means test which has been particularly subject to criticism, is the "family responsibility" provision. Such provisions are found in almost all OAA programs and, in one form or another, in the MAA programs of the following 12 States:

Connecticut	New Hampshire
Hawaii	New York
Illinois	North Dakota
Maine	Pennsylvania
Massachusetts	Utah
Michigan	Vermont

The aged applicant filing for MAA in a State which utilizes family responsibility provisions, thereby, in effect, may subject members of his family to a means test—apart from himself.

In all probability, no other condition attached to application for MAA is as upsetting as the requirement that relatives be investigated and interviewed to determine their ability to contribute toward the health expenses of the applicant for MAA. It is not that families are unwilling to take care of their own. Relatives of the applicant may have already been paying a substantial part of the living expenses of their older relative(s). In some instances, MAA help is requested because the applicant knows that the finances of his family are already under heavy strain. When the older person learns that additional financial aid may be demanded of his family, frequently at what he knows will mean severe hardship, he may well and very often does, withdraw or refuse to make application and let his health needs go unmet.

Some informed comments on the connotations and effects of means test medicine were contained in an article [1] on New York's MAA plan written by State Senator George R. Metcalf, chairman of the State's joint legislative committee on health insurance plans:

> Any attempt to explain the plan's shortcomings inevitably involves a number of criticisms. Frequently heard is the complaint that Kerr-Mills is a welfare program. Although no person is required to sell, mortgage, assign or otherwise lose his home and household furnishings in order to become eligible for medical care, each applicant has to be approved by a welfare investigator. For the sensitive person who resents being seen at the welfare office, this is a burden which he is unwilling to bear. Furthermore, he objects to the fact that a son or daughter can be asked to pay part of his medical bill as a condition of receiving aid. (A number of elderly persons in Buffalo, when informed of this provision, reportedly told the welfare commissioner, "Please kill my application. * * * I don't want my son questioned.") In addition, many people are too proud to let outsiders know that members of their family are receiving welfare help. As the welfare commissioner pointed out to a reporter for the Buffalo News, "No matter how

[1] "New York's Medicare Plan," Hospital Topics, October 1962, p. 35.

badly many people need medical care, when it comes to applying for welfare, they would rather do without it."

The Metcalf committee held a series of hearings during the latter part of 1962 to consider suggested improvements in the State's MAA program. Strong testimony was presented indicating the negative impact of the family responsibility provision in New York's Kerr-Mills program:

In receiving an application for medical assistance for the aged, the public welfare agency should be in a position to assure the aged applicant that full consideration will be given to all legitimate financial requirements of his children and their families. Otherwise the applicant is apt to withdraw his application and he will go without needed medical care when he is told that half of any surplus his children may have over and above their basic living needs, as well as all savings they may have must be applied toward financing his medical needs before he may be considered eligible for public assistance.

I refer particularly to long-planned and long-maintained savings programs by most present-day families to meet the education needs of their growing children. I have seen instances under the present application of the means test where heavy medical expenditures for grandparents have decimated such savings and have deprived grandchildren of full opportunity for a higher education.[2]

James R. Dumpson, commissioner of welfare for the city of New York, told the Metcalf committee:

We believe that this failure to broaden the base of care for the medically indigent aged is due to the restrictive nature and scope of the eligibility requirements of the MAA program; specifically, the requirement of relative responsibility, and the unrealistic ceilings on allowed income and resources and the tying of aid to the existence of substantial medical need. *The pursuit of legally responsible relatives has proven to be a financial mirage.* In my opinion, the administrative cost exceeds the financial returns. A sample survey of MAA cases hospitalized in New York City during March and April 1962 revealed that in only about 10 percent of these cases were legally responsible relatives found to be eligible for billing; and of these cases only 25 percent of the hospital bill was collected. If these figures are applied to our annual experience, then about 2.5 percent of the annual MAA hospital care costs of $40 million or about $1 million is collectible from relatives. To further pursue these relatives in court would be extremely costly.

We also analyzed the contributions of relatives for the cost of care of MAA recipients in nursing homes and infirmaries of homes for the aged during the month of September 1962. Of the 7,400 such cases, 1,275 were receiving contributions from relatives of $763,000 annually toward an annual cost of $21 million. We therefore estimate that the total sums collected from relatives of MAA recipients represents slightly less than 3 percent of the expenditures made in behalf of such persons. *I am convinced that the annual administrative cost of $4,105,000 of administering the MAA program could be cut in half if we eliminated the relative's responsibility and, most important, I believe that this requirement serves to bar uncounted, truly needy, older persons from seeking medical aid under this program.*[3] [Emphasis supplied.]

Commissioner Dumpson then stated: "I therefore strongly support the recommendation that the means test for MAA be limited to the recipient and/or spouse." Of more than incidental interest is the fact that the recommendation was also proposed to the Metcalf committee by the Medical Society of the State of New York—the largest State medical association in the country.

We feel, therefore, that all factors considered, a rather persuasive case has been made for congressional consideration of an amendment to the Kerr-Mills Act which would confine the application of family

[2] Statement of Louis P. Kurtis, commissioner of public welfare, Westchester County, at hearing of Joint Legislative Committee on "Health Insurance Plans," Nov. 16, 1962.

[3] Statement of James R. Dumpson, welfare commissioner, city of New York, at hearing of Joint Legislative Committee on "Health Insurance Plans," Nov. 16, 1962.

responsibility provisions, in those States using such provisions, to the applicant and/or his spouse.

"Liens" under Kerr-Mills MAA

Misunderstanding surrounds the question of whether the Kerr-Mills legislation prohibits States from applying liens as a means of recovering from the assets of MAA recipients, amounts expended for health care under MAA programs.

It has been stated that no liens can be taken on the property of people receiving help under MAA. However, these statements are only partially true.

The provision in the Kerr-Mills legislation relating to liens under MAA requires that the State plan must—

> * * * provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance for the aged paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance for the aged correctly paid on behalf of such individual under the plan.[4]

This means that States can—and 9 of them do—extract from the applicant the right to collect from his estate after death by use of post-mortem claims. The 9 States which have such provisions are Connecticut, Illinois, Massachusetts, Michigan, New Hampshire, New York, North Dakota, Oregon, and Utah.

An MAA recipient living in any of the 9 States mentioned, and possessing the type of property to which liens are applicable, in effect shares in part or all of the cost of the MAA assistance received. His share, however, is not due until after his death (or upon the death of his surviving spouse). Inasmuch as his assets were limited initially (in order for him to qualify for MAA), the effect of these post-mortem recovery provisions is to virtually preclude the possibility of the recipient of MAA leaving anything for his heirs. It may be contended that the cost of MAA care should be recovered from the estate of a recipient—that there is no valid justification for an aged person in need of assistance with medical cost to leave anything for his family. Nonetheless, the prospect of a post-mortem claim on his assets can be another major reason for the deferral, or refusal of necessary health care. The principal consideration in such negative situations may be the desire to leave "a little something" for the education of a grandchild or some similar family need.

California, probably in recognition of these problems in usage of family responsibility provisions, recently dropped the requirement in its MAA plan which provided for relatives' responsibility.

OVERRIDING OBJECTION TO THE USE OF LIENS OR CLAIMS

Fifteen States have apparently recognized the basic problem in usage of recovery provisions and do not employ these devices. Nine States, however, do make use of recovery provisions.

[4] Under old-age assistance, Federal law permits use of current liens and many States make use of such provisions. This should be understood in view of the fact that many MAA recipients are later forced to turn to OAA for help.

Last year's report, "Performance of the States," called attention to what may be the key objection to the usage of "liens," in the Kerr-Mills MAA program:

To today's older American the technical distinction between a lien and a claim is just so much meaningless nonsense. Time and again, throughout this committee's hearings and in all parts of the country, older people made it obvious that anything which in any way threatened their sense of free and outright ownership of the homes they had struggled to make their own was intolerable.

Those of the younger generation who proudly lay claim to "ownership" of heavily mortgaged homes in suburbia may find this idea strange and difficult to understand. Its existence is nonetheless a fact, and a most important fact for the Congress to keep in mind in evaluating programs designed to aid the elderly in a way that will not outrage their sense of decency and dignity.

These older people with whom we are concerned grew up and matured in a tradition of rugged Americanism in which homeownership was an objective of paramount importance. To them "ownership" meant—and still means just that—outright ownership, free and clear. "Paying off the mortgage" was *the* goal in life for every couple. Its achievement, whether the home was valued at $5,000, $10,000, or $50,000 meant that one had proved himself, had acquired the status of a respectable, responsible, "solid" citizen.

To many of our older citizens, the home they own represents the totality of their life savings. This is important of course. But even more important is the fact that with income low or nonexistent, with friends dead or moved away, without the satisfactions that come with employment, an older person's ownership of his home becomes to him the last remaining vestige of dignity, of security, and of independence. These are all too often all that gives life meaning in old age. To rob an older person of dignity, of independence and of the feeling of security, is to make of his life a mockery. The Kerr-Mills Act, itself, does not threaten to take away the home. A claim on one's home enforcible after death does not take that home away. Yet to the elderly, it seems to. To permit the State "to take a mortgage" on the home—whether it is or is not a mortgage in fact—is to admit defeat in life. The intent of Kerr-Mills was to avoid the infliction of such tragedy.

Clear concern with and recognition of this problem—as well as with other inequitable aspects of MAA—was contained in the legislative message of Gov. William W. Scranton, of Pennsylvania, delivered before a joint session of the general assembly on January 22, 1963:

* * * The next major area with which this legislature should be concerned is medical care for the aged.

Once and for all we must eliminate the stigma that this State program is "for paupers only."

Proposals to make the dramatic first steps will be placed before you.

We must increase substantially the limits on assets of eligible elderly persons contained in the present law. (*We must eliminate completely the cruel liens which the State now files against the estates of persons who have received medical aid* * * *. [Emphasis supplied.][4a]

The Governor of Pennsylvania has thus, commendably, acknowledged the serious problem that exists in those States which incorporated recovery provisions into their MAA programs. His statement is acknowledgment of a major flaw in the Kerr-Mills program, to which the Special Committee on Aging has called attention in the past.

Here is another matter for congressional consideration. The Congress may wish to study the advisability of amending Kerr-Mills to either prohibit the usage of recovery provisions entirely or specifically exempt the home of a recipient from the operation of such provisions.

INCOME AND ASSETS LIMITATIONS

The income and assets tests employed by most of the States sharply limit the number of older persons who are eligible for MAA. As table VIII shows, all of the States which specify dollar amounts, with

[4a] Pennsylvania has just announced elimination of the usage of "liens" in its MAA program.

the exception of Oklahoma, have annual income ceilings of $1,800 or less as standards of eligibility for individuals—with six specifying $1,300 or less. In general the tests for couples are only half as much again.[5]

TABLE VIII.—*Limitations on annual income affecting eligibility for MAA, June 1, 1963*

State [1]	Aged individual	Aged couple	State [1]	Aged individual	Aged couple
District of Columbia	$2,100	$2,400	Louisiana	[6] $1,500	[6] $2,100
Oklahoma	2,000	3,000	Maine	1,500	2,100
New Hampshire [2]	1,800	3,000	Oregon	1,500	2,000
Massachusetts [2 3]	1,800	2,700	South Carolina	1,300	2,100
New York [2 3]	[4] 1,800	[4] 2,600	Alabama	1,200	1,800
Illinois	[4] 1,800	[4] 2,400	North Dakota [2 3]	1,200	1,800
Kentucky	1,600	2,400	Arkansas	1,200	1,500
Connecticut [2 3]	[4] 1,550	[4] 2,200	Maryland	[7] 1,140	[7] 1,560
West Virginia	1,500	3,000	Tennessee	1,000	1,500
Michigan	1,500	2,500	California [8]		
Pennsylvania [2 3]	1,500	2,400	Hawaii [9]		
Utah	1,500	2,400	Idaho [2 10]		
Vermont	[5] 1,500	[5] 2,250	Washington [11]		

[1] Includes District of Columbia.
[2] The income limits shown are applicable to persons applying for assistance in paying for medical services other than in nursing homes or chronic care hospitals.
[3] The amounts indicated are those considered necessary for living expenses and are excluded from consideration as being available to meet costs of medical care.
[4] An additional $150 per individual and $250 per couple are allowed to cover health insurance policy premiums.
[5] After deduction of health insurance premiums.
[6] An additional $180 per individual and $300 per couple are allowed for persons with hospitalization insurance. Income in excess of these maximums disqualifies for physicians' services. For hospital care, income in excess of these amounts but less than $3,000 per individual or $3,900 per couple shall be applied to the hospital bill. Income in excess of latter amounts disqualifies for hospital care.
[7] These are the maximums applicable in the 5 largest counties and in the city of Baltimore. In 18 other counties, they are $1,080 and $1,500, respectively.
[8] Estimated average monthly income over next 12 months not expected to exceed the cost of medical care plus cost of maintenance as determined by old-age standard of assistance. Maximum standard for basic items and special need is $171 a month.
[9] Income insufficient to meet standards of assistance established for MAA including nonmedical and medical items. Approximately $50 per month above the standards of assistance of OAA.
[10] Income and resources sufficient to meet the costs of basic requirements, plus $600. Nonexempt assets in excess of $2,000 but less than $10,000 are considered to be available for income.
[11] Income sufficient to cover basic needs, as measured by the department of welfare standard of assistance.

In at least 14 States [6] the restrictions on annual income alone, tend to be more rigid than those employed in determining eligibility for OAA. By way of illustration, an elderly individual with an annual income of $1,499 whose anticipated needs amount to $2,000 might be considered eligible for medical care under the old-age assistance program. In this same State, however, the individual with this same income would automatically be cut off from MAA help regardless of his needs. The reason for this is that in most instances, under OAA, total needs are weighed against total resources available. Under MAA, with arbitrary "cutoff" points, they are not.

Arbitrary "cutoffs", while simplifying somewhat the task of determining eligiblity, do not take into account existing debts for medical care or anticipated medical costs. Thus, in a State with an income limit of $1,200, an aged individual with an income of $1,300 a year who has a heart condition which necessitates medical and nursing home care costing $3,000 or $4,000 a year is ineligible for medical assistance under the MAA program.

[5] For purposes of perspective, app. C consists of a table indicating by jurisdiction the population age 65 and over with no income or annual incomes of less than $2,000. These millions of people are then compared with the number of MAA recipients in those jurisdictions with plans operating in December 1962.
[6] Alabama, Arkansas, Illinois, Kentucky, Louisiana, Maine, Maryland, Michigan, New Hampshire, Oregon, South Carolina, Tennessee, Utah, and West Virginia.

An actual MAA case from the State of Michigan illustrates the effect of use of hard and fast income "cutoffs":

> Mr. B's son made application for MAA on March 29, 1963, on behalf of his father. Mr. B was in a local hospital and the cost of hospitalization was being covered by Blue Cross insurance. However, Mr. B would be in need of nursing home care upon discharge so he applied for MAA.
>
> Mr. B, a widower, lives with his only child, a son. Mr. B owned no real or personal property, but received social security benefits in the amount of $105 per month, plus a pension of $23.50 per month from industry. Therefore, his income was $128.50 per month, with an *annual income of $1,542. This application was denied because of excess income.*
>
> *Mr. B was referred for old-age assistance to cover the cost of nursing home care.* [Emphasis supplied.]

The above case raises several points. First, because of the "hard and fast" income test of $1,500 in Michigan, Mr. B was ruled ineligible for MAA by virtue of having $42 of annual income in excess of the limit. However, he was eligible for the relief program, and presumably, secured the necessary care subjecting himself, of course, to all of the welfare stigmata accompanying OAA.

There is an obvious basic inequity in a test which rules that a person whose income is $1,199 is eligible for full benefits while another with income of $1,201 is not entitled to any help. Recent Federal legislation tends away from such tests, as evidenced by the relatively recent introduction of a sliding scale of pension benefits for veterans and by the significant change in the retirement test under social security.[7]

Another problem arises in States such as Connecticut, Hawaii, Idaho, Massachusetts, New York, North Dakota, Pennsylvania, and Washington, where MAA plans are considerably more flexible in terms of relating the income and assets of an applicant to his needs. The problem stems from the fact that the determination of the extent to which need exceeds resources (or vice versa) is heavily dependent upon the individual judgment of the welfare investigator. Judgments of a broad nature, sometimes required, can result in lack of uniformity of treatment in the handling of relatively parallel cases.

Other uneven and undesirable consequences result from the fact that eligibility for MAA benefits is dependent upon tests of income and assets. Income limitations deter an individual who might otherwise exercise some earning power from so doing because the additional income might make him ineligible for MAA. Similarly, limitations on assets can serve as incentives to transfer and disposal of such assets by aged persons—prior to any actual need for MAA—so as to preserve capital for either themselves or their families while at the same time achieving eligibility. For example, would it not be advisable for the aged individual who is not in immediate need of medical care to take his savings (nonexempt) and pay off the mortgage of his house (exempt)? It certainly would be inadvisable for an individual to sell or mortgage his home for, presumably, the money he received would make him ineligible for aid.[8] Following are actual cases from

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[7] Under the retirement test a beneficiary who earns more than $1,200 in a year has $1 in benefits withheld for each $2 of earnings between $1,200 and $1,700, and for each $1 of earnings above $1,700.

[8] A Federal agency official who reviewed this section of the report (including the Tennessee and Michigan cases) offered the following interesting observation:

"The picture presented here of aged persons is hardly one of the 'worthy' poor which is the general and undoubtedly correct concept of the aged. Isn't it better to argue the point on principle than to present the aged as law breakers or evaders no matter what the rationalization for their behavior. In any case how frequently do aged transfer assets? (Not many have any to transfer)".

Tennessee and Michigan illustrating the undesirable consequences of such tests:

(Tennessee): During intake interview, worker was told that applicant had approximately $800 in savings. Information returned by bank form PA–28 showed that $1,800 had been transferred within last 3 months prior to our request, leaving balance of $841.16. Upon further checking with the bank, we learned that the $1,800 was transferred to the applicant's daughter the day following office interview regarding application for MAA. The case was rejected because it was evident that savings were on hand when application was made and that transfer was made for the purpose of becoming eligible for the program.

(Michigan): At application, the diagnosis was senility and cerebral vascular accident. No property was declared and the income was $81.70 OASI. Applicant was living in the home of a nephew where a son also resided. Applicant had allegedly sold her homestead for $3,900 9 months prior to application and the proceeds had been used by the son to start a restaurant business. The son proved uncooperative in our effort to clarify the transaction and finally, himself withdrew the application indicating he would pay the hospital bill.

We have previously discussed the fact that MAA help, in contrast to a program such as would be provided under the King-Anderson proposal, is made available only after the applicant has reached the point of dependency or semidependency. Table IX provides the details of limitations on asset holdings.

Pennsylvania, it will be noted, has a limitation of $1,500 on assets held by an individual. A case from that State illustrates the inequity, similar to that contained in the "in or out" tests of income, of the use of assets maximums. Additionally, this case impliedly indicates the strain on familial relationships resulting from use of means tests.

The application was received from the hospital. *Withdrawn* because a niece gave information about a bank account of $1,608. She decided to pay her own bill. Diagnosis—intertrochanteric fracture of the right hip. No relatives other than the niece and a sister. *To our knowledge there are no assets other than the bank account.* [Emphasis supplied].

TABLE IX.—*Ceilings on assets for eligibility for MAA, in addition to homeownership, June 1, 1963*

State	Maximum value of asset holdings		Maximum excludes [1]—					
	Individual	Couple	Real property		Other income-producing assets	Surrender value of life insurance	Automobile	Household and personal effects
			Producing	Not for income				
Utah	$10,000	$10,000			(*)		(*)	(*)
Oregon	5,000	5,000			(*)	$1,000	(*)	(*)
Arkansas	2,800	3,100						(*)
Maryland	2,500	2,500						
North Dakota	2,500	2,500						(*)
Idaho	[2] 2,000	[2] 2,000				1,000	(*)	(*)
Massachusetts	2,000	3,000	[3]	[3]		(*)		(*)
Illinois	1,800	2,400			1,000	(*)	(*)	(*)
New Hampshire	1,500	2,500	4,500 or 4,800	500 or 800	1,500	1,000		
Pennsylvania	1,500	2,400			(*)	500 or 1,000	(*)	(*)
Michigan	1,500	2,000			1,000			(*)
California	[4] 1,200	[4] 2,000	5,000				1,500	
Alabama	1,000	1,000	(*)		(*)	2,000	(*)	(*)
Louisiana	1,000	1,500	5,000	1,000	(*)	1,500 or 2,000	(*)	
Tennessee	1,000	1,500	[5] 10,000			1,000 or 1,500		
West Virginia	1,000	1,500	[6] 4,000		(*)	(*)	(*)	(*)
Connecticut	[7] 900	[7] 1,300	(*)	(*)		500 or 1,000		(*)
New York	[7] 900	[7] 1,300				500		(*)
Kentucky	750	1,000	[8] 5,000			3,000		
Oklahoma	700	1,000			4,000	[9]		
Vermont	600	1,200	[8] 2,500		(*)	1,500	(*)	(*)
Maine	500	800	[8] 500 or 800		1,000 or 1,500			
South Carolina	500	800		[10]	(*)		(*)	(*)
District of Columbia	500		[11]	[11]	(*)			(*)
Hawaii [12]								
Washington [13]								

[1] The maximum value of the excluded resource is shown if stated in the plan; if not, an asterisk is used to show that the State excludes some or all of the asset. Where 2 amounts are given, the smaller amount is the limit for single persons, the larger for couples.

[2] Resources between $2,000 and $10,000 are considered to be available for income. In excess of $10,000, they disqualify an applicant for MAA.

[3] Ownership of real property other than home disqualifies.

[4] Includes net value of idle real property.

[5] Maximum equity if unencumbered; maximum equity $8,000 if encumbered; all real property, including home.

[6] Assessed value, including homestead.

[7] Assets in excess of these limits are considered available for medical expenses.

[8] Inclusive, for "income producing" and "not for income" property.

[9] Cash value of first $1,000 face value is excluded for single persons and of first $2,000 face value for married couples.

[10] If nonincome producing, sale value of property is considered under income maximums.

[11] Ownership of real property other than home disqualifies if it is unencumbered and refinanceable; may be held if encumbered by 2 mortgages and not refinanceable, or if encumbered by 1 unpaid mortgage (percent unpaid related to the scale of value of property) and not refinanceable.

[12] All assets are considered as available for "payment" of medical care except real property (value not exceeding $150), and automobile 4 years old or older or when necessary for essential transportation.

[13] All assets are considered as available for payment of medical care, except household and personal effects, life insurance cash surrender value up to $500, and an automobile.

PROBLEMS IN DELAYED AUTHORIZATION OF MAA

There is also the problem of providing MAA to eligibles in time for it to be effective. As table X indicates, it takes an average of 3 weeks to complete the processing of an MAA application.

TABLE X.—*Medical assistance for the aged: Applications received and disposed of and estimated average time lapse from receipt of application to disposal, from inception of program through September 1962, by jurisdiction* [1]

State	Month and year applications first reported	Cumulative number of applications received through September 1962		Cumulative number of applications approved through September 1962		Cumulative number of applications denied or otherwise disposed of	Estimated average number of days lapsing from receipt of applications to disposal [2]	
		Total	Excluding transfers from other programs	Total	Excluding transfers from other programs		Total	Excluding transfers from other programs
Total		445,904	364,481	346,847	265,424	81,454	18	21
Alabama	February 1962	1,882	1,881	1,255	1,254	555	6	6
Arkansas	September 1961	8,949	8,949	7,209	7,209	1,585	6	6
California	December 1961	31,666	13,694	23,523	5,551	5,997	30	69
Connecticut	April 1962	7,264	2,918	5,348	1,002	1,181	15	33
Guam	June 1962	153	153	61	61	0	48	48
Hawaii	July 1961	1,162	940	868	646	269	6	9
Idaho	do	3,530	2,180	3,064	1,714	384	12	18
Illinois	August 1961	8,486	8,486	4,508	4,508	3,049	24	24
Kentucky	March 1961	12,100	11,905	10,309	10,114	1,007	24	24
Louisiana	December 1961	3,471	3,471	2,065	2,065	1,327	9	9
Maine	October 1961	3,212	3,212	2,841	2,841	371	1	1
Maryland	June 1961	19,134	19,134	14,698	14,698	4,261	6	6
Massachusetts	October 1960	51,050	28,497	40,849	18,296	8,631	21	36
Michigan	do	31,422	27,488	24,332	20,398	6,490	12	15
New Hampshire	September 1961	432	432	318	318	89	12	12
New York	April 1961	125,842	97,165	99,498	70,821	23,537	12	15
North Dakota	July 1961	1,999	946	1,697	644	226	21	42
Oklahoma	December 1960	6,724	6,724	5,243	5,243	1,236	18	18
Oregon	October 1961	8,016	7,556	5,642	5,182	2,324	6	6
Pennsylvania	January 1962	35,071	34,983	20,849	20,761	10,257	33	33
Puerto Rico	do	11,972	11,972	10,729	10,729	44	27	27
South Carolina	July 1961	9,955	9,955	6,700	6,700	2,834	21	21
Tennessee	do	9,944	9,944	7,235	7,235	2,217	15	15
Utah	do	1,601	1,093	1,254	746	327	3	6
Vermont	July 1962	231	229	157	155	58	6	6
Virgin Islands	February 1961	624	623	594	593	24	9	9
Washington	October 1960	9,135	9,074	6,537	6,476	2,536	3	3
West Virginia	do	40,877	40,877	39,464	39,464	638	24	24

[1] Preliminary data.
[2] Based on 30-day month.

A few States have attempted to cope with this problem by means of "precertification"—that is, the determination of eligibility prior to actual need.

Precertification of eligibility is valuable in at least two regards. The aged person in need of medical assistance will seek early and timely care if he knows that he has been declared eligible for MAA benefits. On the other hand, uncertainty of eligibility and the possibility of major expense (almost any expense is a "major" charge on the limited resources of the elderly) will frequently deter the seeking of the early care that prevents or minimizes serious illness. In addition, precertification aids in preserving the irreplaceable resources of the older individual. If application is made subsequent to the onset of illness, the applicant may very well have exhausted or

seriously depleted his resources by the time he applies or is certified as eligible for MAA. At that point, instead of being "medically indigent" he is simply "indigent." He is on relief. MAA was supposed to keep people off relief. As table XI indicates, illness and the need for medical care have been major causal factors behind the presence of so many of our aged citizens on old-age assistance rolls.

TABLE XI.—*Old-age assistance: Percentage distribution of cases opened by reasons for opening, by social security status, 31 States, January–June 1962*

Reason for opening	Total opened	Receiving social security benefits	Not receiving social security benefits
All cases	100	52	48
All cases	100	100	100
Total involving health problems	31	39	25
Recipient's earnings reduced because of illness, injury, or impairment	12	12	9
Assets exhausted to meet medical care	7	8	6
Increased need for medical care (with no material change in income or resources)	13	20	9
Other reasons	69	60	78

Source: Bureau of Family Services, Social Security Administration, "Reasons for Opening and Closing Publi Assistance Cases," January–June 1962.

Statements concerning the desirability of use of precertification procedures in the administration of the MAA program have been made in previous publications of the Special Committee on Aging. The legislative message of Governor Scranton, of Pennsylvania, to which previous reference has been made, included this passage on the subject of precertification:

> We must establish machinery whereby the eligibility of elderly persons to receive aid can be determined before illness strikes. A system of determining eligibility in advance will remove the additional suffering needlessly imposed by the present law.[8a]

Precertification of eligibility would, of course, be built into any social security approach to the problem.

The problem of prompt and timely determination of eligibility for MAA is further compounded by the complexity of the eligibility requirements—the means tests [9]—and variations in definitions of medical conditions covered. These, in conjunction with the complexity of the limitations on benefits, make it virtually impossible for a person to understand his rights. It is very doubtful that a person would know whether he is eligible for help. He can feel nothing but insecurity in a situation of this kind. Lack of understanding of the eligibility requirements leads to failure to apply in many cases which could qualify and, as a result, needed care is foregone.

[8a] Pennsylvania has commenced issuing identification cards to qualified individuals prior to actual need for MAA services.

[9] Recognizing this problem, Senator Dirksen has proposed an amendment to the Kerr-Mills legislation (S. 305) which would provide that an applicant's statement as to his financial status, if made under oath, shall be "presumed to be factually correct for purposes of determining his eligibility." While passage of this amendment might expedite certification of eligibility, it would not, of course, eliminate investigation of the applicant's financial status to evaluate the accuracy of the statements made under oath.

CHAPTER IV

THE LIMITED AND INADEQUATE SERVICES OF MAA PLANS

Having navigated the tortuous eligibility maze successfully, albeit reluctantly, the applicant's expectation of relief is all too often not realized. As is frequently the case, the range of assistance available does not include what he needs or else it is inadequate. And, assuming the necessary services are available, his "freedom of choice" of doctor or hospital may be nonexistent, with care available only in specified facilities or from specified physicians.[1]

SCOPE AND EXTENT OF MAA BENEFITS

Question. "In Kentucky, what happens if the hospital patient is still sick after 6 days?"

Answer. "We pay only for 6 days. If the patient is in the hospital longer, the care may be paid for by a relative or a charity, or the hospital may discharge him. We do not know what happens after our responsibility is met."

The above question was asked at the Fifth Annual Medical Services Conference of the Council on Medical Service of the American Medical Association, held in Los Angeles, Calif., on November 25, 1962. The answer to the question was supplied by Earl V. Powell, commissioner of the Department of Economic Security of the State of Kentucky. The theme of the conference was "Kerr-Mills in Action—1962."

Commissioner Powell's response is indicative only of an inability—not of an unwillingness—to provide help beyond the minimal aid authorized under Kentucky's program of medical assistance for the aged.

Kentucky has since been able to extend the duration of its responsibility to 10 days for each hospital admission. Given the financial resources available, this extension is a signal achievement. Given the health care needs of the elderly, however, it is not enough. And, given the forum where Commissioner Powell offered his revealing reply, the situation is not without a touch of irony. The American Medical Association had, in full-page advertisements, hailed Kerr-Mills MAA because, "its benefits are unlimited."

Much of the testimony offered in support of the Kerr-Mills legislation prior to its passage was to the same effect as the advertised claim of the AMA. MAA benefits could, theoretically, be virtually "unlimited" because of the "open ended" matching offer of the Federal Government. It has been said, however, that the reach of the Federal offer far exceeds the grasp of the States. Almost every State excludes or limits benefits for at least one, or in many instances several, major areas of health expense.

Of the 25 States, and 4 other jurisdictions with programs in effect on June 1, 1963, only 4—Hawaii, Massachusetts, New York, and North Dakota—have plans which can be classified as "comprehensive"

[1] App. D consists of a summary of the eligibility requirements and the scope and contents of services for each of the 29 jurisdictions with MAA programs in operation on June 1, 1963.

in terms of the definition established by the Bureau of Family Services of the Welfare Administration:

> The "comprehensive" programs have been defined as those which include all five kinds of services [2] with no significant limitations on illnesses needing care or the extent of care given. "Intermediate" programs can have either (*a*) five kinds of services, with important restrictions on one or more, or (*b*) three or four services, with significant qualifications affecting one or more. "Minimal" programs provide two of the five kinds of care, with or without limitations.

According to these criteria, the Bureau of Family Services rates the 29 plans as follows:

> Comprehensive: Hawaii, Massachusetts, New York, North Dakota.
> Intermediate: (*a*) California, Connecticut, District of Columbia, Guam, Kentucky, Utah, Washington, West Virginia; and (*b*) Arkansas, Idaho, Louisiana, Maryland, Michigan, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Virgin Islands.
> Minimal: Alabama, Illinois, Maine, New Hampshire, Vermont.

Comprehensiveness is an essential element of a good medical care program not just because it meets a broad range of medical expense, but because it is the only way of assuring "appropriateness" of care. The physician caring for the aged person may select the most appropriate site and type of treatment and, at the right time—be it care at home, hospital, or nursing homes.

Any national program claiming to offer unlimited benefits would necessarily have to offer such comprehensiveness in all, not just four, States. And, in one of those four States, the Medical Society has questioned the "comprehensiveness of the program." In testimony before the Metcalf committee in New York, Dr. James Greenough, chairman of the Committee on Public Health and Education of the Medical Society of the State of New York, said:

> While the emphasis in present medical welfare cases has largely been on curing the disease after it has occurred, modern medical science provides the knowledge and the techniques for the prevention of certain diseases, the early detection of others before the symptoms begin, and the rehabilitation of the patient. *The application of this knowledge in the MAA program has not been adequate.* [Emphasis supplied.]

Table XII indicates the percentage distribution by type of service of the $250 million in vendor payments made under the MAA program during calendar year 1962. As will be noted, 95 percent of the payments went for hospital and nursing home care.

The fact that almost all of the MAA payments are going for hospital and nursing home care, despite the frequent limitations on the amount of such services provided to a recipient, indicates recognition by the States that these two types of medical care are the most needed and press most upon the elderly. This recognition and experience of the States should certainly be considered as justification of the emphasis upon hospital and skilled nursing home benefits as the "floor of protection" sought to be established by proposals such as the King-Anderson bill.

[2] The five services are: (1) Hospital care, (2) physicians' services, (3) nursing home care, (4) prescribed drugs, and (5) dental care.

TABLE XII.—*Medical assistance for the aged. Vendor payments for medical care by jurisdiction and by type of service, calendar year 1962*

[Amount in thousands]

Jurisdiction	Total	Percentage distribution by type of service						
		Physicians	Other practitioners	Inpatient hospital	Prescribed drugs	Nursing home	Dentists	Other
Total: [1]								
Amount	$250,836	$5,452	$338	$121,057	$5,122	$117,343	$213	$1,312
Percent	100.0	2.2	0.1	48.3	2.0	46.8	0.1	0.5
Alabama [2]	$393	.6		99.4				
Arkansas	810	6.3	(3)	70.2		18.0	1.8	3.6
California	46,046	1.0	.2	54.7	.9	42.5	.1	.6
Connecticut [2]	6,731	.9	.2	5.1	2.4	90.8	.1	.6
Guam [2]	11		30.3	63.2	6.5			
Hawaii	1,195	.3	.1	12.4	.7	86.3	(3)	.2
Idaho	2,090	10.1		18.6		71.3		
Illinois	2,414	4.6		95.4				
Kentucky	535	19.0		58.1	22.2		.7	
Louisiana	793	11.5		83.0	.2	5.2	(3)	(3)
Maine	750			100.0				(3)
Maryland	2,557	7.1		77.1	14.1		.2	1.4
Massachusetts	43,111	2.0	.4	21.6	5.2	69.8	.2	.9
Michigan	18,726	3.7		93.5		2.4		.4
New Hampshire	41	20.1	.1	78.2				1.7
New York	102,887	1.2	(3)	47.1	1.0	50.3	(3)	.2
North Dakota	1,961	6.9	.2	25.1	6.3	59.9	.1	1.6
Oklahoma	1,119	24.8		68.6		5.1		1.4
Oregon	516	23.0		70.7		6.2		(3)
Pennsylvania [2]	10,615			60.7		38.6		.7
Puerto Rico	530			89.3				10.7
South Carolina	1,023			93.8		3.6		2.5
Tennessee	413			87.6	10.9	1.5		
Utah	1,265	6.8		15.8	3.0	74.3	(3)	.2
Vermont [2]	63	.1		99.9				
Washington	1,632	7.5	.4	74.4	1.2	16.5	(3)	.1
West Virginia	2,609	24.2	(3)	52.8	21.0	.8	.1	1.1

[1] Excludes $26,000 for the Virgin Islands; distribution by type of service not available.
[2] MAA program in operation less than 1 year.
[3] Less than 0.05 percent.

NOTE.—Details may not add to totals due to rounding.

Table XIII indicates the number of different recipients who received one or more types of MAA benefits during the fiscal year 1962. The data are, of course, not directly comparable with table XII, for the latter covers calendar year 1962. Nonetheless, table XIII does offer a working guide to the range and frequency of medical services provided. This is particularly true with regard to analysis of the experience of the four States with comprehensive programs. Obviously, little meaningful information may be gained from analyzing the experience of those States which do not include particular types of services in their MAA plans or limit them substantially. Further caution in evaluating table XIII should be taken in view of the fact that there is a vast difference in the cost of the various types of benefits. For example, while more persons received prescribed drugs than received nursing home care, far more money was spent for the latter type of care. (See table XII.)

TABLE XIII.—*Medical assistance for the aged: Number of different recipients who received 1 or more types of medical or remedial care, by jurisdiction, fiscal year 1962* [1]

Jurisdiction	Average monthly number of recipients	Number of different recipients who during year received—							
		Any type of care	Inpatient hospital care	Nursing home care	Physicians' services	Other practitioners' services	Dental care	Prescribed drugs	Other care
Total [1]	74,394	217,797	109,283	71,750	99,561	14,679	2,332	80,592	24,987
Alabama	126	706	703		92				
Arkansas	820	3,836	1,656	214	2,039	7	56	506	1,039
California	10,624	18,572	8,590	10,389	7,036	1,855	235	7,540	3,395
Connecticut	3,948	4,347	116	3,952	257	574	7	1,814	163
Hawaii	267	783	372	535	186	58	7	159	10
Idaho	1,068	2,441	1,040	1,312	1,867	45			15
Louisiana	211	1,465	1,317	40	736			126	2
Maine	265	1,470	1,470		14				
Maryland	4,638	8,807	4,332		4,854	1,229	177	6,561	73
Massachusetts	18,557	30,133	9,848	19,818	21,257	9,129	1,175	22,635	10,730
Michigan	4,649	13,585	12,825	663	5,113				1,488
New Hampshire	25	120	87		84				
New York	27,791	69,900	39,500	28,500	22,850	1,150	300	17,650	3,350
North Dakota	650	1,237	538	737	1,027	26	37	961	455
Oklahoma	309	2,363	2,042	115	1,972		4		136
Pennsylvania	1,935	12,915	9,181	3,695					465
Puerto Rico	1,417	8,732	2,174		6,865				
South Carolina	441	3,217	2,720	88					779
Tennessee	282	1,921	1,205					886	
Utah	332	956	242	631	497	5	1	445	14
Washington	563	3,723	2,312	918	2,117	18	36	1,472	1,441
West Virginia	6,685	26,568	7,013	143	20,698	583	297	19,837	1,432

[1] Preliminary data. Data not yet available for Guam, Illinois, Kentucky, Oregon, and the Virgin Islands.

PROVISIONS FOR HOSPITAL CARE [3]

All of the 29 jurisdictions with MAA programs in effect as of June 1, 1963, afforded some inpatient hospital care to their eligibles. Of these jurisdictions, 15 limited the number of days of care provided and/or the types of conditions covered:

Alabama
Arkansas
California
Idaho
Kentucky
Louisiana
Maine
New Hampshire
Oklahoma
Oregon
South Carolina
Tennessee
Utah
Vermont
Washington

The limitations and restrictions can be quite severe. For example, Kentucky provides no more than 10 days of care per admission for "acute, emergency, and life endangering" conditions only; New Hampshire generally limits covered care to 12 days per admission; Oregon provides up to 14 days per year with the recipient paying $7.50 per day for the first 10 days; and Idaho makes available 14 days per admission for acute, emergency, and contagious conditions only, with diagnostic tests and X-rays paid for only up to $50. Tennessee affords 15 days of hospital care per fiscal year for acute illness, injury, or life-endangering conditions. A case from the latter State illustrates the inadequacy of the benefit:

[3] App. E presents in chart form the 5 major types of services, indicating which of these are included in the MAA plans of the 29 jurisdictions. Footnotes provide information on limitations, where applicable, on each type of service.

Recipient has congestive heart failure. She was admitted to the hospital and remained 15 days. After 1 week at home it was necessary to be readmitted to the hospital for treatment.

Mrs. P has no income and is entirely dependent upon her daughter for support. MAA has provided 15 days' hospitalization for the recipient *but cost for additional days in the hospital will have to be paid for by the daughter who works to meet her own needs.* [Emphasis supplied.]

Restriction of payments for care to cases of "acute, emergency, and life endangering" conditions may result in serious consequences. Aged persons suffering from chronic conditions such as cataracts, diabetes, nephritis, arthritis, or cardiovascular disorders would probably not qualify for Kerr-Mills MAA help in States with such restrictions unless their conditions became extreme. Lack of timely medical care contributes to the probability that such conditions will become "acute and life endangering." Chronic conditions are especially prevalent among the aged. Persons aged 65 and over are twice as likely to suffer chronic conditions as those under age 65.

In the context of the generally acknowledged need for continuing care—the preventive, therapeutic, and restorative treatment called for in such cases that prevents acute episodes and major aftereffects—the limitations of these MAA programs are unsound both in medical and humanitarian terms.

THE EFFECT OF DEDUCTIBLES

The use of a flat deductible or contributory payment, as illustrated by the Oregon benefit for hospital care, limits the scope of care for which payment is made by some MAA plans. In some States the applicant is ineligible for assistance, regardless of actual need or ability to pay the deductible until the deductible conditions have been met. For example, the limited scope of care in Tennessee is further narrowed by the fact that hospital care expenses are not assumed by the State under MAA unless the applicant first incurs hospital expenses of over $25 in a fiscal year. Illinois will make payments only for medical care costs which exceed 10 percent of the combined annual income of the applicant and his dependents. Oregon sets different deductibles for different types of medical services, $50 a benefit year for physicians' services, etc.

California had originally made payments for institutional care only after the applicant had spent 30 days in a hospital or skilled nursing home. Recent amendments to the MAA plan now make care available to the older person during the first 30 days if he receives his care in a county or county-contracted hospital, or in a nursing home to which the individual is transferred from these facilities. The older person who receives care in a private institution can only get help, prior to the expiration of 30 days, if he has spent $2,000 for care. As a practical matter, the latter provision would apply to only a few of the most catastrophic of cases. Because of the fact that relatively few of the elderly possess $2,000, and the financial incentives placed upon care in county institutions, it appears that California's MAA program represents a definite step toward "socialized medicine," with care provided in governmental facilities by salaried physicians on public payrolls. As California is very often a trend-setter among the States in matters of public welfare, its approach to the provision of Kerr-Mills MAA care should be a cause of great alarm to those who

fear "socialized medicine." In contrast to this, "freedom of choice" of hospitals and physicians is expressly guaranteed by proposals such as the King-Anderson bill.

There is no question but that State and local governments are having increasing difficulty in finding the tax resources they need for schools, roads, welfare, and other necessary functions of local governments. Furthermore, local taxpayers are often reluctant to increase their own burdens to finance programs of which they themselves will not be the beneficiaries. This is why, as we have pointed out elsewhere, so many States cannot raise sufficient tax funds to give relief clients the minimum amounts of money that those States have indicated they should have. With these considerations in mind, it is only logical to assume that other States will carefully analyze the California approach. They too will see that not only can they save considerable amounts of tax funds in the care of MAA patients by requiring such patients to use county hospitals and "government doctors," but will also find that the use of Federal funds, under MAA, can relieve them of a great portion of the taxload now used to support county hospitals. Any such program, so obviously attractive to local taxpayers and tax raisers, can be expected to spread far beyond the boundaries of California. On the other hand, the same taxpayer, takes an altogether different attitude toward programs in which he himself is or will be a beneficiary. If, for instance, he is paying into a social security fund from which his own hospital care will be paid after he is 65, it is safe to say that he will insist that such program guarantee his right to choose his own physician and his own hospital, thus preserving the freedom of American medicine.

In a program such as MAA, where the scope should be broad in terms of the population group served and the health services provided, the use of deductibles works the greatest hardship on those most in need, while those least in need find raising the money for the deductible no great barrier. It is logical to assume that those aged persons who are most needy are the least likely to have health insurance or relatives who are willing and able to provide for part of their medical needs. Therefore, such restrictions work to the decided disadvantage of those people for whom the program is really designed. It is recognized that some—but not all—of the proposals for hospital and related benefits under social security include provisions for deductibles. However, in any program necessitating the taking of a means test to establish inadequacy of resources such as Kerr-Mills MAA does, the use of deductibles is contradictory and self-defeating.

Deductible provisons often function to deter necessary care as opposed to "unnecessary" care. When limited resources are available for basic necessities such as food, clothing, and housing, the eligible aged individual would tend to postpone necessary medical care in order to apply the $25, $50, or $100 toward those other necessities. A deductible does not encourage the early and timely care that prevents and minimizes serious illness. The problem thus becomes one not of "overutilization" of services but rather one of "underutilization."

The basic answer to controlling "unnecessary" usage of services is not the imposition of fiscal controls upon the medically indigent which force the individual to judge the necessity and urgency of care in relation to this financial situation. The answer lies in the use of medical controls whereby the aged person's physician and the physicians who

comprise medical review boards are responsible for the decisions as to the necessity, appropriateness, and duration of medical care.

It is on the personal physician of the individual that we must place first reliance for seeing to it that a program of medical care is not exploited. It is the physician and only the physician who can decide whether a patient should be hospitalized and for how long.

The prevention of over utilization or exploitation of a medical care program—whether it be Kerr-Mills, Blue Cross, commercial insurance, or the Veterans' Administration program—is a responsibility first of the individual doctor and, secondly, of the medical profession. Concern is often expressed over the possibility that individual physicians will succumb to the temptation of hospitalizing people unnecessarily for the convenience of the physician or patient, or the pocketbook of the physician or patient. It is on the physician's colleagues, functioning on the medical review boards, that we must rely for the imposition of proper and effective disciplinary controls over the presumably few malefactors or irresponsible people in the profession. Any suggestion that a "deductible," a financial bar to utilization of services, solves this problem of medical ethics is sheer nonsense. Deductibles and co-insurance have been aptly termed "fiscal gadgetry" by Walter J. McNerney, president of the Blue Cross Association.

Recognition of the need for establishment of utilization committees in hospitals is firmly offered in a recent report of the Commission for the Cost of Medical Care of the Florida Medical Association. Reporting on its extensive survey of Florida hospitals, the commission stated:[4]

> First, there *is* a definite trend toward practicing medicine in the hospital and the surrounding medical care facilities which now cluster around each hospital.
>
> Second, there *appears to be* a definite trend toward an increasing degree of unnecessary utilization of hospital health care facilities.
>
> Third, the Commission believes that the *establishment of an active utilization committee* in each hospital can greatly assist the physicians on the staff and the hospital administrative personnel to exert a greater effort toward efficient and effective utilization of the facilities which are available in the hospital.

Both the American Hospital Association and Blue Cross have urged hospitals to establish review boards. The desirability of such committees is virtually self-evident. Doctors—not dollars—should determine the appropriateness and availability of medical care.

NURSING HOME CARE

Twenty-one of the twenty-nine jurisdictions include care in nursing homes as part of their MAA programs:

Arkansas
California
Connecticut
District of Columbia
Hawaii
Idaho
Kentucky
Louisiana
Massachusetts
Michigan
New York
North Dakota
Oklahoma
Oregon
Pennsylvania
Puerto Rico
South Carolina
Tennessee
Utah
Washington
West Virginia

[4] "Is There Any Unnecessary Utilization of Hospital Facilities in Florida?" A report of the Florida commission on the cost of medical care, May 1963.

Most of these States limited the provision of such care with respect to the maximum payments and Michigan, Oklahoma, Oregon, South Carolina, and Tennessee limit the number of days covered. A case from the State of Tennessee indicates what happens to the MAA recipient who needs nursing home care beyond the number of days authorized under MAA:

Mr. B has had treatment for asthma and high blood pressure since 1939. He lost the vision of one eye in 1947. He attended Vanderbilt outpatient clinic for years and medical expenses were minimum. He has a history of myocardial infarction (several years ago), arteriosclerotic heart disease, post left lumbar sympathectomy and pulmonary emphysema. He was hospitalized February 1963 for a urinary (bladder neck) obstruction and early gangrene of left foot. He has glaucoma in the left eye.

The recipient has no income of his own and makes his home with a widowed daughter. He formerly received old-age assistance from 1950 to 1956 when his grant was cancelled *due to assumed income* from his children.

Mr. B was certified for MAA on December 5, 1962, and has received the maximum benefits from this program. He was hospitalized 15 days, has received 90 days' nursing home care and is presently receiving drugs.

Nursing homes are licensed but ungraded in Tennessee. In Vanderbilt Hospital it is assumed he received medical and surgical care comparable to any other patient. *He is still in need of nursing home care and remains in county hospital and nursing home as a county-paying patient.* He will be eligible for 90 more days of nursing home care during the next fiscal year beginning July 1, 1963. [Emphasis supplied.]

Illinois is among the States that do not include skilled nursing home care in their MAA programs. But such care may be made available to MAA eligibles under the relief program in that State. As Raymond Hilliard, director of the Cook County Department of Public Aid, phrased it, in commenting upon MAA cases: "* * * one fact does stand out. Recipients of MAA services who subsequently required nursing home care found it necessary to apply for old-age assistance." Obviously, "unlimited benefits" are not quite provided under Illinois MAA plan. An actual case from that State illustrates the problem:

Mrs. B is an 82-year-old widow who was living alone in a roominghouse prior to her hospitalization. Mrs. B's only income is $67.70 per month OASI as a widow. Her husband died 16 years ago. Her daughter, a 58-year-old widow, is supported by her own three children and cannot contribute to her mother's care. A niece has helped Mrs. B meet her medical expenses in the past and also became involved in this instance.

Mrs. B has a history of a chronic heart ailment. She was hospitalized for chronic pulmonary congestion and *at the time of her discharge from the hospital it was necessary for her to enter a nursing home. The niece paid $81.74 of the total hospital bill of $782.54.* Mrs. B was accepted for old-age assistance when she entered the nursing home. [Emphasis supplied.]

A number of States set maximum limits on payments to nursing homes—$105 monthly in Arkansas, $135 monthly in West Virginia, and $150 monthly in South Carolina, for example. Such limitations make it virtually impossible to provide nursing home care of a character beyond mere custodial care. Skilled nursing home care is expensive, limited payments in behalf of MAA eligibles (and OAA recipients, as well) lead to toleration of so-called nursing homes, which are travesties on the name, and discourage the growth of nursing homes that can effectively meet the range of needs of the aged.

It might well be contended that on its face it is misrepresentation to say "nursing" care is being provided in return for payment of $100 to $150 a month. In fact, the question may be justifiably raised as to whether the Federal Government should contribute to such payments under what Congress created as a *medical* care program.

Custodial care is *not* medical care. To hide sick elderly people away in institutions which cannot possibly be providing the *skilled* nursing care they need and to pretend that we have thereby met their medical needs attains the heights of self-deception.

PHYSICIANS' SERVICES

Twenty-eight of the twenty-nine jurisdictions include some kind of services of physicians in their programs, although in three of them (Maine, Puerto Rico, and South Carolina) such care is available only in outpatient clinics, and in two others (District of Columbia and Pennsylvania) only through a "home care" or "home-hospital" program. The exception is Tennessee which does not pay for physicians' services.

Where such services are provided, care rendered in the office, home or outpatient department of a hospital is generally limited in terms of visits or services in a given period. The kinds of conditions for which care will be provided are also often limited. By way of illustration, the coverage of physicians' services in Idaho combines the several elements of restriction and limitation: No provision is made for physicians' services rendered to an MAA eligible who receives care in hospital or in the outpatient department of the hospital; office and/or home calls are covered for acute conditions only—to the extent of two visits per month for both types; one call per month is covered for a recipient who is in a nursing home, and one eye examination is authorized per 6-month period. (No eye care is authorized, however.)

DENTAL CARE

Seventeen of the twenty-nine jurisdictions provide some dental services: Arkansas, California, Connecticut, District of Columbia, Guam, Hawaii, Kentucky, Maryland, Massachusetts, New York, North Dakota, Oklahoma, Puerto Rico, Utah, Virgin Islands, Washington, and West Virginia. Care is frequently provided only for cases of acute infection, and emergencies and the services available are usually restricted to fillings and extractions even though a major health need of the aged is for dentures to replace extracted teeth.

PRESCRIBED DRUGS

Despite the fact that aged persons spend more than twice as much, on the average, for medicines as does the entire population, and despite the fact that almost 25 percent of the per capita health expenditures of aged persons is for drugs, only 19 of the 29 jurisdictions make provision for such costs in their MAA programs:

California
Connecticut
District of Columbia
Guam
Hawaii
Kentucky
Louisiana
Maine
Maryland
Massachusetts
New York
North Dakota
Puerto Rico
South Carolina
Tennessee
Utah
Virgin Islands
Washington
West Virginia

Louisiana provides drug coverage only for MAA recipients in nursing homes. Washington affords drug benefits only when the prescriptions relate to "acute and emergent" conditions. Maine, Puerto Rico, and South Carolina cover drugs as a part of outpatient clinic care.

In summary then, the benefits available—when available—under the various MAA plans are very definitely not "unlimited." As may also be observed, the various limitations and restrictions (apart from the exclusions) are not determined by the actual needs of the aged person but, in fact, by the available financial resources of each State.

FREEDOM OF CHOICE

The American Medical Association, in a full page advertisement, offered as a major reason for its support of Kerr-Mills:

> It preserves the quality of medical care—maintaining the patient's freedom of choice and the doctor's freedom to treat his patients in an individual way.

Actually, the Kerr-Mills legislation contains no provision assuring the recipients of medical care under MAA of freedom to choose a hospital or nursing home or doctor or pharmacist.

In fact, there are explicit and implicit limitations on all three of the AMA premises—"quality of medical care," "patient's freedom of choice," and the "doctor's freedom to treat his patients in an individual way."

Both the "quality of care" and the "patient's freedom of choice" can frequently be affected by the relative willingness of physicians and hospitals to negotiate and accept MAA and OAA payments—which are often below the "going" rates.

Some doctors and hospitals, it would appear, occasionally apply their own means tests, which may be stricter than that of the State. In West Virginia, one of the issues between some of the physicians and the State concerned the desire of the doctors to have the right to charge MAA patients a *fee in addition* to that paid by the State. This approach of some physicians may further deny full "freedom of choice" to the MAA beneficiary. The aged person may be unable to pay a supplemental fee to the physician and consequently feel obliged to seek medical care elsewhere.

Louisiana's Department of Public Welfare reversed previous policy in January 1963 and now permits hospitals to collect the difference between the amount billed and the amount paid by the Welfare Department from the MAA recipient and/or his relatives.

An article in the Detroit News of March 12, 1962, also hints at the problem. The director of the Wayne County Board of Social Welfare, Walter J. Dunne, referring to the MAA payments to physicians and hospitals, which are lower than usual charges, was quoted as saying:

> Because of this discount, private hospitals would prefer patients with insurance or who can pay themselves. * * * Some hospitals are restricting intake in the Kerr-Mills and old-age assistance cases.

Recent contacts with welfare officials in the State of Michigan indicate that the problem of acceptance of welfare allowances by hospitals persists, and is even more acute than previously.

An article with the interesting title of "Socialized Medicine? We've got it in Kerr-Mills" appeared in a recent issue of the magazine Medical Economics (Apr. 22, 1963). The article, written by a Louisiana physician, Dr. Fred A. Marx, has some rather strong

statements concerning the lack of "freedom of choice" in MAA, at least in Louisiana:

1. *Free choice of physician.*—The welfare department booklet blandly asserts: "All (Kerr-Mills) recipients have free choice of physician." Having paid lip service to medical ethics, however, the bureaucrats then created some practical difficulties that tend to keep that guiding principle from being carried out. Once a patient chooses a doctor, he's issued a card with the doctor's name on it. As far as that patient is concerned, this is the only doctor whose bill the State will pay. Before switching to another physician, the patient must notify the welfare department and wait for a new card to be processed. The process is clumsy and time consuming. Thus, it discourages free choice.

After dealing in similar fashion with: *Freedom to call in specialists*, *freedom to operate*, and *free choice of pharmacist*, Dr. Marx offers a statement illuminating another interesting aspect of "freedom of choice":

5. *Freedom of nonparticipation. About half the doctors in my State choose not to participate in Kerr-Mills.*—I'm sure many of them agree that nonparticipation is a hollow freedom. It forces a physician to deny a patient the law's benefits. Moreover, it pits the lone private practitioner against the toughest most tamper-proof monopoly going—Government monopoly.

If the doctor can't tolerate the consequences of nonparticipation, his remaining choice is to participate. When he does, he's tied to the State in all Kerr-Mills dealings, just as surely as if he were on the State's payroll. * * * [Emphasis supplied.]

Something of a contrast to Dr. Marx' attitude was provided by the Commerce and Industry Association, Inc. of New York in its statement on "freedom of choice" delivered before the Metcalf Committee on November 16, 1962:

Physician's services also are provided for under the existing law. We therefore see no need to provide by legislative action for "free choice of physician at an adequate fee." The best of medical care should be provided, but determination of who is to provide it and what is a reasonable fee for a private physician should be left to the administrators of the program through rules or regulations.

The statements of Dr. Marx and the Commerce and Industry Association, despite the overriding pursuit on the part of the latter of economy and the former of illusion, reflect, in good part, the realities of many MAA plans.

Several of the MAA programs sharply restrict the recipient's choice of hospital or physician. Under such circumstances, the physician's "freedom to treat his patients in an individual way" suffers when his patient must be confined in a particular hospital—in order to qualify for assistance—with which the doctor may not be affiliated. Such situations make for "fragmented" medical care—there is a lack of continuity of treatment. The physician, in such cases, takes his patient up to the door of the hospital and must then relinquish him to a staff member. Among those jurisdictions which have MAA programs directly restricting the individual's "freedom of choice" are:

District of Columbia.—Hospital and clinic care provided only in specified public and voluntary hospitals under contract with the Department of Health. Nursing home care in one public facility only.

Hawaii.—Outpatient care is provided by "government doctors," who also dispense drugs to an extent.

Puerto Rico.—Hospital and outpatient care available only in governmental facilities.

The failure to cover in-hospital physicians' services in many jurisdictions and the use of State, county, or teaching hospitals in others where the MAA plans do not include explicit restrictions requiring the use of house staff physicians, nevertheless means that many of the recipients of MAA must depend upon the services of hospital staffs and clinics. They may well receive their treatment in charity wards. No doctor-patient relationship of an enduring nature and no choice of physician is present under these conditions.

The constructive attitude of the Medical Society of the State of New York toward improving Kerr-Mills MAA was made apparent in previous pages of this report. The society's outline of areas for improvement in terms of the quality of care provided in New York's MAA program, presented to the Metcalf committee on November 16, 1962, included sections pertinent to MAA plans in all of the States:

> In only a few counties or cities are welfare medical programs under the direction of full-time and adequately trained medical personnel. In many areas throughout the State the administration of medical care suffers keenly from a lack of sufficient personnel and the adequate training of existing personnel. It is impossible to develop a modern medical care program to meet adequately the needs of welfare recipients without such trained supervision. * * *
>
> There has been too great an emphasis in programs for the Medical Assistance to the Aged recipients on a presumed "economy," to the detriment of the principle of continuity of medical care. This lack of continuity results when several physicians are alternately or simultaneously responsible for a patient without proper communication between them about the facts relating to the patient. This means extra and unneeded repetitious diagnostic treatment and laboratory procedures. In the case of extra, unneeded X-ray exposure this could be a significant health hazard. Such duplication materially increases the cost of care, is an inhumane burden for the patient to bear and makes good-quality care difficult to provide. It also acts as a serious deterrent to the participation of our best qualified physicians in welfare medical care programs.
>
> There is no uniform program for insuring high-quality medical care for MAA recipients throughout New York State. In some areas many physicians serving welfare patients do not have an affiliation with an accredited hospital. If physicians are to be kept abreast of the latest medical advances and have the opportunity to work closely with their colleagues, the general guidance, stimulation, and consultation of a well-organized hospital service is recognized as a requirement for modern day medical care. Therefore, when physicians do not have hospital affiliations there should be more careful review of their qualifications and the reason for the lack of affiliation determined. * * *
>
> In many areas of the State, professional fees paid for medical care are not commensurate with the value of the services rendered. This acts as a deterrent to the improvement of medical care and the recruitment of the most competent and best trained physicians in the community.

Certainly, the statements above are to the point. Unfortunately, the quality of care envisaged is, as has been pointed out, dependent upon much more liberal financing of MAA programs. Unfortunately, also, most of the States cannot generate the necessary funds—at least at present. Enactment of a social security-financed program of hospital and related benefits would "free," in good part, State funds now spread thinly and inadequately. These funds could then be concentrated on services not covered by the social security program, thereby achieving a program adequate in terms of the extent and quality of medical care services. Our older Americans deserve no less.

INDIVIDUAL VIEWS OF SENATOR GEORGE A. SMATHERS

While I regret the negative tone of this report, I believe it provides valuable information on the operation of the MAA program, its weaknesses, and the needs for its improvement. Unless and until another Federal program is enacted, MAA offers the most practical means available to assist senior citizens with their medical problems. It, therefore, behooves Congress to correct the weakness revealed by this report and make MAA a more effective instrument in achieving this important objective.

GEORGE A. SMATHERS.

MINORITY VIEWS OF SENATOR EVERETT McKINLEY DIRKSEN, SENATOR BARRY GOLDWATER, AND SENATOR FRANK CARLSON

Improvement in methods of financing medical care costs for persons past 65 has been rapid and substantial during the past several years.

This improvement, which has been both quantitative and qualitative, has resulted in part from a continuation of higher income among older people, in part from volatile expansion and refinement of voluntary health insurance, in part from development of public programs encouraged by Federal grants-in-aid to the States and in part from continued growth of State and local aid programs which do not employ Federal funds.

It is almost inconceivable that an effort be made to evaluate any one of these major elements relating to medical care of older people without clear and careful reference to accomplishments by the others. Yet this is precisely what has been attempted in the majority report.

It says:

> The findings of this report confirm the conclusions of earlier studies that the MAA program did not, and could not by itself, constitute an effective national solution to the pressing and pervasive problems connected with the financing of the hospital and related expenses of the Nation's senior citizens.

The Kerr-Mills Act medical assistance to the aged program, with which the report is concerned, was never expected "by itself" to provide the sole avenue for financing medical care for the Nation's 18 million persons past 65.

Congressional intent regarding the medical assistance for the aged program, as set forth in the Kerr-Mills Act, was to enable the States—

> to furnish medical assistance on behalf of aged individuals who are not recipients of old-age assistance but whose income and resources are insufficient to meet the costs of necessary medical services.

OTHER STATE PROGRAMS

Expansion of the medical care aspects of the old-age assistance program by the same act indicated the desire of Congress to continue medical services under that program to persons receiving cash public assistance, now approximately 12 percent of the Nation's over 65 population, and to afford greater flexibility to the States in developing medical programs for older people with limited or no resources. This action regarding the OAA medical vendor payment program has resulted in this type of benefit being newly made available to at least 600,000 people in 11 jurisdictions and in an expansion of OAA coverage under such programs in 4 other States to include the medically indigent, not in need of subsistence payments. To ignore this, is to leave out an important part of the picture.

The majority statement fails, also, to take into account State and local programs providing medical care for older persons with-

out Federal grants. Conceding that information about such programs may be difficult to assemble, their existence must be recognized in any appraisal of medical care for older people.

One striking example in this regard is the State of Colorado. It has not enacted MAA, but it does have a medical care program, State supported, which as of June 30, 1962, covered 53,000 persons, 32 percent of the State's over 65 population.

It is interesting to note further, that the Colorado State Legislature, apparently on the basis of its experience, adopted a resolution opposing enactment of a medical service program under the social security system.

VOLUNTARY HEALTH INSURANCE

That voluntary health insurance, and its role in meeting the needs of older people, should be disregarded in an appraisal of MAA, however, probably constitutes the most glaring omission in the majority statement.

According to a report made by J. F. Follmann, Jr., director of information and research, Health Insurance Association of America, at the end of 1961, 55 percent of the people past 65 had voluntary health insurance coverage.[1]

It should be noted that this report is almost 2 years old. Since then there has been an intensive development and sale of new health insurance plans for older people. These have included mass enrollment plans requiring no physical examination. Several companies have sold over 1 million each of such plans. Further, there has been development in this period of associated insurance company programs for persons aged 65 and over in Massachusetts and New York. Paralleling efforts by insurance companies have been those by prepayment plans such as Blue Cross and Blue Shield, which currently cover in excess of 5 million persons past 65.

Nor is there substantiation for the claim, oft repeated, that those persons without health insurance are unable to pay for it.

In reporting on a survey of persons past 65 conducted by the National Opinion Research Center of the University of Chicago, Ethel Shanas, who directed the study, said:

> All persons who had no health insurance were asked whether they would be interested in obtaining coverage. Half of them said they would be, but that they could not afford it (34 percent of the total) or that "they won't sell me any" (16 percent). One-fourth said flatly, "I don't want it," and the same proportion said "I've never thought about it." [2]

The new insurance plans, developed since the 1957 Shanas study, undoubtedly constitute an answer for the 16 percent who said "they won't sell me." Assuming continued validity of the survey's findings, this would leave roughly one-third of the uninsured (one-sixth of the total over 65 population) who deem their own finances to be insufficient to permit purchase of insurance. How many of these are now beneficiaries of old-age assistance medical services, Veterans' Administration medical benefits, the Kerr-Mills medical assistance for the aged program, and other federally supported programs, would provide a valuable area for study.

[1] Follmann, J. F., Jr., "Private Health Insurance Protection for the Aged," address presented before the School of Public Health, University of California, Apr. 30, 1963.
[2] Shanas, Ethel, "The Health of Older People," Harvard University Press, 1962.

While there is agreement that some older people need and should have services related to medical care provided in part or totality through Federal and State funds, an attempt to appraise such programs without reference to private plans inevitably will be deficient.

That voluntary health insurance, supplemented by public programs where needed, is the Nation's method of choice for financing major medical costs is indicated by congressional mail and the results of polls conducted by Members of Congress.

Of 33 recent polls of their constituents by Members of Congress (23 Republicans and 10 Democrats), 31 produced majority views against a Federal social security system program. In these tabulations, of those expressing an opinion, the percentage opposing the social security approach ranged from 54.1 percent to 94.9 percent; in 13 of these polls over 70 percent of those voicing an opinion opposed the compulsory program.

Connecticut, whose MAA program is the object of criticism by implication in the majority statement, affords one of several instances wherein disregard of health insurance can be fatal to an accurate evaluation. As of now, 85 percent of that State's 65-plus population has voluntary coverage.

Any judgment regarding long-term policies of the Federal Government with reference to medical care for older people must, to be most valid, give recognition also to improving levels of income among older people. They strongly suggest that the percentage of older people unable to provide for their own needs has declined in recent years and further reduction in income deficiencies may be expected to continue in the future.

Older people today want to maintain their own independence, including the freedom to make their own decisions as to how money available to them shall be spent. Presumably older people of tomorrow will have similar desires for individual freedom.

These legitimate preferences, coupled with rising income patterns for older people, clearly suggest that Federal Government involvement in provision of services related to medical care for senior citizens should remain flexible.

Certainly any compulsory program, unrelated to need, would permanently freeze the Federal Government's role in medical care for individuals. It would involve serious dangers for the existing medical care system now based on maximum exercise of private initiative and individual responsibility.

IMPROVING INCOMES

How retirement income patterns are changing was noted in the minority views contained in the 1963 report to the Senate by the Special Committee on Aging as follows:

> Roger F. Murray, professor of banking and finance, Columbia University Graduate School of Business, in his appearance at a committee hearing in 1961, said: "During the past decade, there has been an explosive growth in the number of people covered by retirement plans designed to supplement their prospective benefits under the old-age and survivors insurance system. The number of covered employees in private industry, for example, is currently about 22 million, representing a growth of close to 50 percent in the last 5 years. In Federal, State, and local governments, of course, the coverage is close to completion." (The latter category embraces over 10 million employees.)

A more comprehensive summary of this growth is contained in the report by the House Committee on Education and Labor on H.R. 8723, 87th Congress, amending the Welfare and Pension Plans Disclosure Act, which stated: "Figures relating to pension plans show that their number grew from 7,400 in 1945 to an estimated 25,000 in 1960, while the number of persons covered moved from 5.6 million to approximately 80 million.

"Tabulations introduced into the record of the subcommittee hearings show that in 1959 the assets of both welfare and pension plans amounted to over $50 billion; and that they were growing at a rate of from $4 billion to $5 billion a year.

"It is clear that these plans have now become, on the one hand, a cornerstone to the protection of many millions of our citizens and their families; and, on the other, a vast and continuously increasing body of funds, which exercises a significant effect on the national economy."

The 87th Congress enacted H.R. 10, a measure which will enable self-employed individuals to establish pension plans for themselves. In order to enjoy these benefits, however, they must also provide for their own employees. The stimulus thus given to retirement programs for the self-employed and their employees should accelerate further the expansion of private pensions.

The same minority report emphasized the importance of income and the right of individuals to spend it as they, themselves, prefer.

Since the major problems among the aged are largely economic, highest priority should be given to those actions by the Government which would—

(1) Increase social security payments, especially minimum benefits;

(2) Permit persons over 65 greater flexibility in their use of social security without loss of benefits;

(3) Increase employment opportunities for older people and reduce elements in Government policies and programs which interfere with senior citizens' full use of opportunities which now exist;

(4) Pursue policies to encourage rapidly growing private programs for helding people prepare for the economic requirements of later years;

(5) Eliminate unnecessary Government spending and thereby reduce the already serious impact of inflation on retirement income.

Concurrently, efforts should be accelerated to achieve full implementation of programs already enacted by Congress to meet the needs of older people who may now be confronted with special hardships.

MAKING MAA WORK

One of the major programs to prevent hardship cases referred to therein, of course, is the medical assistance for the aged (MAA) program created by the Kerr-Mills Act.

Certainly every effort should be made at both Federal and State level to make the program work. Possibly amendments to the act will be required to clarify and completely implement congressional intent.

Whether one approves or disapproves of the approach envisioned by the Kerr-Mills Act, it is the law of the land. As such, its implementation should receive the full support of Federal officials. The negative tone of the majority statement depreciates this concept and thus tends, in itself, to help create a climate in which many older people may be denied the services intended.

It may be expected that the program will work if given full support.

UNWARRANTED AND PREMATURE CONCLUSIONS

To conclude, as the majority opinion has, that MAA is not working, will not work, and cannot work is to form a premature judgment based on inadequate evidence.

This prematurity and inadequacy is reflected repeatedly in specific conclusions in the majority views. It is sufficient to cite a few examples from that opinion's introduction and summary.

The majority statement says in part:

> Although all 50 State legislatures have met since this program was enacted into law, 3 years ago, only 28 States and 4 other jurisdictions now have the program in operation.

Actually six other States have enacted legislation necessary to implement MAA. Eleven States, containing 15 percent of the people past 65, have neither enacted legislation nor have it pending. These include Texas, which is awaiting a constitutional referendum necessary before MAA passage and several which have created study commissions to develop program recommendations. They include two States (Indiana and Missouri) where legislation was enacted but vetoed by their respective Governors. They also include Colorado and several other States which reportedly feel existing State programs are adequate. If the concept of State responsibility is to continue to have meaning, it would appear prudent that the right to exercise this judgment at the levels of government closest to the people should be maintained.

The majority opinion further says:

> Stringent eligibility tests, "lien type" recovery provisions, and responsible relative provisions have severely limited participation in those jurisdictions where the program is in operation. In August of 1963, only 148,000 people received MAA assistance—or less than 1 percent of the Nation's older citizens.

The use of monthly figures, of course, seriously minimizes aid rendered; approximately 370,000 received MAA during fiscal 1962–63. More significant is the fact that not all potentially eligible older people needed the services. In addition, it must be remembered that approximately 12 percent of the over-65 population were eligible for benefits under the old-age assistance program.

The implication that family responsibility and "recovery" programs are improper is highly debatable. It should be noted that, in accordance with the Kerr-Mills prohibition of home liens, no recovery is permitted in any State from the older person or spouse; it can only be applicable to the beneficiary's heirs. Whether this is right or wrong, it would appear appropriate that the decision be made at the State level. The same logic applies to the requirement that families who are financially able should take care of their own members before State programs are invoked.

The most serious implication in this majority quotation, however, is that "low usage" automatically means "inadequacy." This is based on the highly questionable assumption that there is a vast unmet need for medical care among older people. It is equally and perhaps much more plausible that this "low usage" may be due to the adequacy of other existing mechanisms. In fact it suggests that coverage by other programs may be exceedingly good.

The MAA record in the Chicago area affords evidence that assumption of adequacy may be the more correct conclusion.

The Bureau of Labor Statistics has developed what some budgetary experts regard as a "liberal budget" for couples and individuals past 65 for 20 major cities. For couples in Chicago (the highest of these 20 cities) it is $3,112 per year and for individuals living alone, $1,836 a year. Since the budgets, respectively, include $160 and $90 for gifts and contributions and assume rental of living quarters (most older couples and many single persons past 65 own their own homes), it appears reasonable in terms of the BLS budget, which may be high,

to assume that $3,000 and $1,800 constitute adequate or more-than-adequate incomes.

Under Illinois MAA, individuals who do not have other resources available to them are eligible for benefits if their income is below $1,800. The maximum income requirement for a couple to be eligible is $2,400 per year. Apparently Illinois State officials and the legislature felt this was a more accurate determination of adequacy than the BLS budget. Whether the Illinois Legislature took homeownership and other factors into consideration in arriving at this income figure is not clear, but presumably they gave careful consideration to all factors in the situation of the State's older population.

In any event, by whichever standard is used, it would appear that the vast majority of older persons in the Chicago area whose incomes might be termed "inadequate," are eligible for MAA.

The fact that "only" (to use a word oft repeated in the majority views) 5,474 MAA applications were approved and "only" 2,039 were denied, withdrawn or otherwise disposed of in Cook County (of which Chicago is the county seat), during the first 23 months of the program's operation, reinforces the view that the alleged unmet need has often been greatly exaggerated. Since 192 denials were based on the "family responsibility" provision of the law, this appears an insignificant factor.

Another quote from the majority statement says:

> The duration, levels and types of benefits vary widely from State to State. Except for those four States having comprehensive programs (Hawaii, Massachusetts, New York, and North Dakota) benefits are nominal, nonexistent, or inadequate.

Whether a program is "comprehensive," "intermediate," or "minimal" is based on definitions developed by the Bureau of Family Services of the Department of Health, Education, and Welfare with regard to the type of services provided. According to these definitions, which are set forth in the majority report, the administration social security financed proposal would qualify as a "minimal" program, unless one regards services by interns and residents in teaching hospitals and services by anesthesiologists, pathologists, radiologists, and physiatrists in the hospital as fulfilling the qualification regarding "physician services."

The significant fact is, however, that there is no real evidence for jumping to the conclusion that even "minimal" standards according to these definitions can be equated with inadequacy. The type of benefits cannot be isolated from other medical programs in the State. Tennessee, for example, contains no provision for physician services in its MAA program. An agreement by the Tennessee physicians voluntarily entered into and insisted upon by them, however, assures such services to all hospitalized persons unable to pay. In a similar way all of the States (six) referred to in the majority statement as omitting nursing home care do provide such services when needed through their OAA programs.

Continuing examination of the majority views, one finds the statement:

> Administrative costs of MAA programs remain too high in most jurisdictions.

These represent initial costs during periods when the programs are being set up and which are always high. It is too soon to determine actual administrative cost ratios for the program.

Another majority statement quotation says:

> The distribution of Federal matching funds under MAA has been grossly disproportionate, with a few wealthy States, best able to finance their phase of the program getting a lion's share of the funds. Five States, California, New York, Massachusetts, Michigan, and Pennsylvania, for example, received 88 percent of all Federal MAA funds distributed from the start of the program through December 31, 1962, although those five States have only 32 percent of the Nation's elderly people. New York alone, with 10 percent of the Nation's elderly, received 42 percent of this total.

The five States referred to have 56 percent of the over-65 population in States with MAA. They are urban, industrial States which tend to greater use of assistance programs. Since they are among the States with the highest total and aged population, highest medical costs, and highest utilization patterns, their share of Federal medical funds will always tend to be greater than their share of the population.

Still another quote from the majority opinion says:

> The congressional intent to extend assistance to a new type of "medically indigent" persons through MAA has been violated by the practice of several States in transferring nearly 100,000 persons already on other welfare programs, mainly OAA, to the Kerr-Mills program. The States have done this to take advantage of the higher matching grant provisions of Kerr-Mills, saving millions of dollars in State costs, but diverting money meant for other purposes.

The Kerr-Mills Act was designed to expand care for all older persons unable to finance it themselves. There is no proof that money has been diverted for other purposes. On the contrary, while the OAA caseload decreased 1.8 percent from May 1962 to May 1963, expenditures have increased 5.2 percent.

A final example from the majority statement says:

> The "welfare" aspects of the Kerr-Mills MAA program, including cumbersome investigations of eligibility, plus the requirement in most States that resources of an older person must be depleted to a point of near dependency, have further reduced participation.

The undocumented charge regarding eligibility investigations, if true, could easily be resolved by adoption of an amendment to the Kerr-Mills Act introduced by Senator Dirksen (and previously passed by the Senate, but rejected by the House of Representatives) or a similar change in the basic law.

A simple review of current eligibility requirements in the several States with MAA programs in operation or under development and a relating of such requirements to average per capita incomes and living costs in each will demonstrate the inaccuracy of the charge that "most States" require reduction of MAA beneficiaries to a "state of near dependency."

It should be noted further, with reference to this particular point and the entire majority statement, that careful examination of future developments under MAA, possible, probable, and certain, unfortunately has been given little attention. A number of States have and will have under consideration improvements regarding benefits, eligibility requirements, and other facets of Kerr-Mills operation. Among plans recently approved by State legislatures, but not yet in operation, are some which introduce new concepts.

MAA INNOVATIONS SHOULD BE ENCOURAGED

One innovation is the proposed plan by South Dakota to purchase voluntary health insurance for persons who qualify under the State's MAA program. Although spokesmen for South Dakota discussed this plan with Health, Education, and Welfare Department officials at length prior to adopting the legislation, as of October 10 approval by HEW was not yet forthcoming.

It would appear, however, that it was the intent of the Kerr-Mills Act that States be free to purchase voluntary health insurance for MAA beneficiaries. Encouragement of this type of approach certainly would be appropriate on the part of the Department of Health, Education, and Welfare and all others interested in adequate medical service for older people.

CONCLUSION

In conclusion, it would seem that the majority opinion that—

The evidence available after 3 years of Kerr-Mills operation demonstrates conclusively that the congressional intent has not and will not be realized—

will not stand up under even the most casual review.

The fact that much of the data used in the majority statement is based on a period when many States were getting started and some were engaged in perfecting plans authorized, but yet to be inaugurated, underscores the inconclusiveness of the evidence presented therein.

It bears repeating, further, that the preferred method of most Americans for meeting the major costs of medical care is voluntary health insurance. This is true of both young and old. This preference should be encouraged.

Because availability of adequate income wherever possible constitutes the best way to express such encouragement, the highest priority in Federal Government policies relating to older people should be those aimed at improving income and at preserving the dollar's value so such improvements will have maximum beneficial effect.

Everett McKinley Dirksen.
Barry Goldwater.
Frank Carlson.

SUPPLEMENTAL VIEWS OF SENATOR HIRAM L. FONG

It is gratifying to observe Hawaii's medical assistance for the aged program described as one that provides comprehensive services. It reflects the firm desire of Hawaii's citizens to adequately care for their elders. It would appear that all States could do likewise in keeping with their own unique needs and resources.

The comments in the minority views with reference to the prematurity of any current judgment of the Kerr-Mills Act appear to be well taken. The program is new. Despite the comparative speed with which most States have taken action to effect its purposes, more time and experience with the various programs and their continuing improvments would seem desirable before seriously considering abandonment of the concepts of Federal aid on which present law is based.

It is, nonetheless, fitting that both majority and minority views consider the possibility of some changes in the Kerr-Mills Act.

This coincides with my view that additional legislation is needed. While persisting in the opinion that the proposal jointly sponsored by Senators Saltonstall, Aiken, Scott, Boggs, Prouty, Cotton, and myself during the last session of Congress contains the most desirable elements for such legislation, it should be recognized that Kerr-Mills Act amendments along such lines might be a satisfactory legislative avenue for their accomplishment.

This plan, based on sharing of cost by Federal and State Governments with the advantages of State administration, gives three choices to all persons over 65 whose annual income for Federal tax purposes is below specified levels. The choices would give beneficiaries an option to choose (1) a diagnostic, preventive, short-term illness plan, (2) a long-term illness plan, or (3) private health insurance.

It is appropriate that the desirability of such an approach be reiterated as a part of this document.

The recurring suggestion in the majority report that social security financing is desirable impels me to comment.

Social security financing of medical care for the aged is grossly unfair. It would put the burden very heavily on wage earners regardless of their income or ability to pay. The $5,200-a-year clerk would pay as much social security tax as the $50,000 corporation president.

It would be especially hard on young people, struggling to feed, clothe, house, and educate their children and protect them currently with medical insurance, to be forced to shoulder at the same time the tax for hospital insurance for the aged. Through all their working years, America's working men and women would be compelled to pay a social security health insurance tax, yet receive none of the benefits for themselves until they reached age 65. Should they die before age 65, they would receive nothing for all their payments.

Social security taxation for aged health insurance is a very regressive tax, hurting most those in the lowest wage brackets. About fifty percent of America's workers earn wages of $5,000 a year or less.

Under the social security financed insurance plan of the administration, even those of the blind, the handicapped, the domestic workers, and the farmworkers who pay social security taxes would be taxed to pay for health care of the well to do.

Meantime, 40 percent of all taxable income in the United States on which no social security tax is levied would escape any responsibility whatsoever to help in this problem, including the income of 9 million American workers not in the social security system.

In October 1962, the Hawaii Medical Service Association informed me that the medical benefits proposed under the administration's social security plan could be offered in Hawaii for each senior citizen at an estimated $7.10 per month, or $85.20 per year.

Under the administration's proposed social security tax plan, an employee earning $5,200 annually, which is the maximum salary to be taxed, would pay $27.50 a year more than the tax he now pays under social security. If an employee age 20 would deposit this $27.50 in an insured savings and loan association each year for 45 years at 4¾-percent interest compounded quarterly (this rate is common in Hawaii and West Coast States), he would have a nest egg of $4,093.78 at age 65.

If he continued to invest the $4,093.78 at 4¾-percent interest compounded quarterly, he could pay for an excellent medical care insurance policy with the $197.94 in interest on his savings each year and get better coverage than the administration's plan would provide. Or, he could buy the benefits of the administration plan for $85.20 and still have $112.74 left over.

Most startling of all, after he died, his nest egg of $4,093.78 would go to his family. Should he die before age 65, say at age 60, his family would inherit his savings of $3,126.16. Under the administration plan he would build no nest egg. Actually, the administration would have consumed his goose.

As one who voted for the Kerr-Mills law in 1960 and who has cosponsored an excellent voluntary health insurance plan for those aged persons not eligible for Kerr-Mills or old-age assistance, I believe there are better ways than the social security plan of the administration to meet the remaining problem.

All of us want to make sure proper medical care is received by our elderly citizens, those who arrived on this earth before us and to whom we owe so much.

As they reach their sunset years, and as others reach them tomorrow, next year, and in the years to come, their security and dignity are on our conscience.

Now in the twilight of their years, some of our senior citizens are in need of assistance. We must see to it that they enjoy their remaining years in peace and dignity, not as wards of the Federal Government, but as free citizens, able to live their lives in gracious fulfillment. As the administration plan is woefully inadequate, Congress should continue to explore better ways to meet the need.

HIRAM L. FONG.

APPENDIXES

Appendix A

Efforts of the Department of Health, Education, and Welfare To Assist Implementation of the Kerr-Mills Program

Department of Health, Education, and Welfare,
Social Security Administration,
Bureau of Public Assistance,
Washington, D.C., September 16, 1960.

State letter No. 431.

To State agencies administering approved public assistance plans.
Subject: Social Security Amendments of 1960 (Public Law 86–778)—Implementation of law.

On September 13, the President approved Public Law 86–778, the Social Security Amendments of 1960. You have already received State letter No. 427, dated August 31, a summary of the provisions as they relate to public assistance. One copy of the enrolled bill was sent to each State director. The Secretary of Health, Education, and Welfare has also written all the State Governors recommending that the States take necessary action to implement the new law. Thus, both the Congress and the Department have recognized the need for legislation to aid the aged in meeting their medical bills. We know that State welfare departments are also reviewing their situations to determine what steps can be taken to bring the benefits of this program to the aged in their States.

This legislation increases the Federal share in old-age assistance provided in the form of payments for medical care and authorizes new grants for a program of medical assistance for additional aged persons. It thus provides an opportunity for States to improve and expand the medical services now available to the group of individuals most subject to acute and severe illness.

The conference report on the legislation contains this statement:

"It is expected that these additional old-age-assistance vendor medical care funds will result in the improvement of programs for such care, or for initiating programs of medical assistance for the aged, or both."

Inasmuch as October 1, 1960, the effective date for the amendments to title I, is so close at hand, I am sure you will recognize the serious problem faced by the Bureau of Public Assistance in developing the necessary interpretations and statements of requirements for State plans.

In order to provide as much help as we can for State planning, we are enclosing a preliminary statement on the status of some of the policy and administrative questions involved.

We are working as rapidly as we can to develop preliminary material in other areas and to complete the materials needed in order to provide them in more formal form. We have had the benefit of discussion with a small group of State representatives and expect to consult as many others as possible.

Materials are also in preparation regarding the OASDI revisions as they affect public assistance, and the revision in earned income exemptions in aid to the blind.

We shall very much appreciate your keeping us informed of plans you are making or considering for the enrichment of the present provisions for medical care for older persons.

Sincerely yours,

Kathryn D. Goodwin, *Director.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
BUREAU OF PUBLIC ASSISTANCE,
Washington, D.C., January 19, 1961.

State letter No. 453.

To: State agencies administering approved public assistance plans.
Subject: Bureau leaflet, "Medical Aid for Older Persons Through Public Assistance."

This letter transmits a copy of the new public information leaflet, "Medical Aid for Older Persons Through Public Assistance." The publication deals with the medical care provisions that are included in the old-age assistance and medical assistance for the aged programs.

There has been a great deal of interest from the public in the medical care provisions, which became effective October 1, 1960. The leaflet attempts to answer the questions that are most frequently asked and to give helpful information on the Federal provisions and other factors of the two public assistance programs that provide medical care for the aged.

Because of public interest, the leaflet has been prepared in sufficient quantity for wide distribution. Additional supplies of the publication may be obtained without charge from the Bureau.

Sincerely yours,

KATHRYN D. GOODWIN, *Director.*

MEDICAL AID FOR OLDER PERSONS THROUGH PUBLIC ASSISTANCE

1. Can an elderly person obtain help in paying his medical bills under the Federal-State public assistance programs?

The availability of such help depends on the person's own State. Each State decides whether to pay for the costs of medical care in public assistance. It may initiate a program of medical assistance for the aged. It may also include the costs of medical care in the aid given under its old-age assistance program.

2. Is a State obliged to help the elderly with their medical costs?

Each State decides what public assistance programs it will administer. Many States provide for medical care under the old-age assistance program which operates in all States. Many States are now deciding whether to participate in the medical assistance for the aged program, as authorized in the 1960 amendments to the Social Security Act. In this program, the State has wide latitude in establishing eligibility conditions and in determining the scope of medical services for which it will pay. Each State receives Federal funds to help pay for its public assistance programs operated under the Social Security Act.

3. What is medical assistance for the aged?

When available in a State, this program serves aged persons of low income who cannot pay for necessary medical care and who are not receiving old-age assistance. The aid consists of payments directly to those who have supplied medical services to the recipient.

4. What is old-age assistance?

This program, in operation in all States, helps elderly persons who lack money for their basic needs. It makes money payments to the needy person. Some States also pay his medical care costs; their payments may cover fairly comprehensive medical services, or only limited care.

5. What requirements must a person meet to qualify for medical assistance for the aged in a State that operates this program?

A person must be 65 or more years old. He must lack money for necessary medical care, according to his State's requirements on maximum income and resources. He cannot be receiving old-age assistance. He must meet other conditions prescribed by his State as permitted by Federal law.

6. How much money can an elderly person have and still be eligible for public aid to help him pay for necessary medical care?

Each State that provides medical assistance for the aged establishes its own limits on income and other resources to determine whether people are of "low income." In covering medical care costs under old-age assistance, each State establishes its own test to determine who are "needy" persons.

7. How long must a person live in a State before he can qualify for aid in paying for necessary medical care?

In a State that operates medical assistance for the aged, a person meets the residence requirements of the program when he resides in the State or

is temporarily out of the State. For old-age assistance, a State may require the needy aged person to have lived in the State for as much as 5 of the past 9 years. Under the Social Security Act, however, no State has to have a residence requirement in either medical assistance for the aged or old-age assistance.

8. May an aged person receive medical assistance for the aged and another type of public assistance from the same State at the same time?

He may receive medical assistance for the aged while receiving aid to the blind, the disabled, or (as a relative) dependent children, or general assistance. But he cannot be an old-age assistance recipient.

9. To obtain aid with his medical costs, must a person assign his property and other resources to the State?

When a person receives medical assistance for the aged, the State cannot impose a lien on his property while he or his spouse is alive. In old-age assistance, some States use security devices relating to property to enable them to recover some or all the money they have paid to, or on behalf of, the assistance recipient. However, the States do not usually take steps to recover while the aged person or his spouse is alive.

10. Can an aged person who is covered by Federal old-age and survivors insurance obtain either medical care, or money to pay medical bills, as a part of his benefits under that program?

Old-age and survivors insurance consists of cash payments based on a person's past working record. An aged person cannot get additional benefits because of his medical needs. However, OASI beneficiaries who qualify for public assistance may receive supplementary help under old-age assistance or medical assistance for the aged.

11. How does an elderly person apply for public assistance to help him pay for medical care?

To apply for any kind of Federal-State public assistance, the elderly person, or a relative or friend, visits, telephones, or writes the nearest public assistance agency to arrange an appointment. During this appointment, he tells the agency worker about his situation.

12. How does the local public welfare agency assist an aged person who needs help with medical costs?

The agency worker helps the person determine whether he qualifies for the aid that his State provides under either medical assistance for the aged or old-age assistance. If the person is eligible, the agency, together with his doctor, establishes his medical needs. It may help him arrange for care. The agency pays the doctor, the hospital, and any other suppliers of medical services whose costs are covered by the State's program.

13. Can a qualified person get help with all kinds of medical care costs in a State that operates a medical assistance for the aged program?

Under Federal law, the State is required to help with costs of both institutional and noninstitutional care. Within this range, however, the State decides on the services that it will pay for.

14. How does Congress define "necessary medical care" in the Federal legislation on the medical assistance for the aged program?

The 1960 amendments to the Social Security Act identify such care as inpatient hospital services; hospital and clinic services to outpatients; nursing home, private nursing, and home health care services; physicians' and dentists' services; physical therapy and related services; prescribed drugs, eyeglasses, dentures, and prosthetic devices; diagnostic screening; preventive services; and other medical and remedial care recognized under State law. Each State decides whether to pay the costs of some or all these services.

15. If a person believes he has not been treated properly by the local public assistance agency, what can he do?

When an applicant or recipient is not satisfied with his agency's action on his case as it relates to help under medical assistance for the aged or old-age assistance, he may ask either the local or the State agency to arrange for a fair hearing before State staff who have not previously made decisions about his case.

16. Does the Federal Government give equal money to all the States for the assistance that they decide to provide for elderly persons?

The Federal Government is concerned with improving the welfare of the aged, wherever they live. To help the elderly obtain more nearly equal aid under public assistance, the Federal share in State assistance costs is proportionately larger for low-income States. The Federal grants are based on formulas established by Congress for the programs.

17. How can anyone help the aged to obtain aid in paying the costs of necessary medical care?

Every citizen should know the sources and scope of public medical aid in his community. The local public welfare agency has information on the types of aid that are available under the State's public assistance programs. It can also explain the requirements that an elderly person must meet in order to qualify for public assistance.

18. Can the average person do anything about improving his State's provisions for helping the elderly with their medical expenses?

A person can find out what his State and his county do under existing public assistance programs. He can work with community leaders and groups in establishing or expanding necessary medical services. Since medical assistance for the aged and old-age assistance are based on State law, the citizens may find it necessary to work toward new or changed legislation.

19. How do the Federal-State public assistance programs help the elderly to share in the goals for all human beings?

By providing money and other welfare services, and by paying for needed medical care, old-age assistance and medical assistance for the aged can help elderly persons to share more fully in these common goals:

Enough money for daily living.
Participation in family and community life.
Management of one's own affairs.
The use of one's experience and skills.
Prompt, necessary medical care.
Humane protective care when necessary.

Actions Taken by the Department of Health, Education, and Welfare To Implement Kerr-Mills Provisions—1960 Amendments to Title I, Social Security Act

The implementation of any changes or expanded provisions of legislation dealing with State-Federal grant-in-aid programs such as those under title I of the Social Security Act ultimately rests with the State, the State legislature, and the official State agency. The 1960 amendments expanding the provisions under title I of the Social Security Act, including medical assistance for the aged, were not mandatory on the State. If a State chooses to participate in the program, it can either accept medical assistance for the aged or claim the increased matching under old-age assistance. The role of the Federal agency in implementing a new program of this sort is limited as in any State-Federal grant-in-aid program. Nevertheless within these limitations, the Department has proceeded to encourage maximum implementation of the intent of Congress. On September 15, 1960, only days after enactment of Public Law 86–778, the Secretary of the Department of Health, Education, and Welfare indicated his support for the new program by writing each Governor a letter describing the special provisions for aged persons, and offering the Department's assistance to the States to enable them to proceed with their planning.

The Bureau of Family Services of the Welfare Administration (formerly the Bureau of Public Assistance, Social Security Administration) is the unit in the Department of Health, Education, and Welfare responsible for administering the public assistance titles of the Social Security Act. This Bureau began working with the State assistance agencies before the enactment of the 1960 amendments, to gain a better understanding of the States' problems in providing medical care for the aged and to acquaint them with some of the proposals.

Immediately following enactment of the Kerr-Mills provisions, the Bureau of Family Services met with a representative group of State directors of public assistance to discuss the new amendments, to explore tentative policy positions being taken by the Bureau, and in general to assist in understanding the new provisions.

Since the Kerr-Mills amendments relate so largely to medical care, it was recognized that the Bureau must also work closely with hospitals, doctors, physicians, and other medical personnel concerned. To facilitate this, the Bureau appointed a group of consultants on medical matters. This group, among its other functions, assists in gaining better public understanding. Bureau representatives met with the American Medical Association's Committee on Indigent Care on a number of occasions to exchange information and answer questions

directed toward better understanding among physicians. The American Medical Association's Washington News Letter of December 1960 expresses that group's interest and its general position in support of medical assistance for the aged.

In 1961, after preliminary discussion between staff of the Bureau of Family Services and representatives of the American Hospital Association, the association appointed a committee to meet with the Director of the Bureau of Family Services to discuss matters of mutual interest. This group has met three times with the Bureau. The American Hospital Association undertook to canvass hospitals to determine common problems, which were then explored in meetings with the committee. Plans were worked out to maintain effective relations between the American Hospital Association and the Bureau. Also, it is planned to hold a jointly sponsored series of regional meetings, the first of which will be held in Denver, Colo., on March 21 and 22.

The technical medical staff of the Bureau, in the Division of Medical Care Standards, has prepared guides as well as handbook (regulating) material to assist State agencies in planning for and administering medical services for recipients. The staff of this division has participated in a number of national and regional meetings. The technical medical staff also assists States to consult with State aging staff, and on occasion with representatives of the State medical society and State hospital association. These consultations have related to possible ways to implement a medical assistance for the aged program in the State.

At the present time, 25 States plus Puerto Rico, Guam, and the Virgin Islands have programs of medical assistance for the aged in operation. The following material includes a table which shows the action taken by the States to date to implement the Kerr-Mills provisions, and the steps which have been taken by the Department to assist in this implementation:

REPORT FOR JANUARY 31, 1963—ACTIVITIES OF THE 54 JURISDICTIONS TO PUT INTO EFFECT THE NEW PROGRAM OF MEDICAL ASSISTANCE FOR THE AGED

A. Programs in effect,[1] 28 States:

Alabama	Maine	Puerto Rico
Arkansas	Maryland	South Carolina
California	Massachusetts	Tennessee
Connecticut	Michigan	Utah
Guam	New Hampshire	Vermont
Hawaii	New York	Virgin Islands
Idaho	North Dakota	Washington
Illinois	Oklahoma	West Virginia
Kentucky	Oregon	
Louisiana	Pennsylvania	

B. Plan submitted; not in effect, none.

C. Legislation enacted; plan not yet submitted, 1 State: New Jersey (effective July 1, 1963).

D. Legislation in process to give basis for program or to provide appropriation, four States—bill introduced: Indiana, Ohio, and South Dakota. Other status: Nevada (bill being drafted).

E. Need legislation, 17 States:

Alaska	Kansas	North Carolina
Arizona	Minnesota	Rhode Island
Colorado	Mississippi	Texas
Delaware	Missouri	Wisconsin
District of Columbia	Montana	Wyoming
Florida	Nebraska	

F. Have authority for medical assistance for the aged program not yet implemented, 4 States:

Georgia: Enacted 1961; no funds available.
Iowa: Enacted 1961; no appropriation.
New Mexico: Plan withdrawn; no appropriation.
Virginia: Enacted 1962; appropriation effective January 1, 1964.

[1] Plans of these States are approved.

1. Basic implementing activities

Prior to and directly after the passage of the medical assistance to the aged bill on September 13, 1960, much material was prepared and consultations held to discuss programing for medical care for the aged. The more pertinent actions during this period were—

June 28, 1960.—A statement from Commissioner William L. Mitchell to J. A. Kieffer, Assistant to the Secretary, summarizing "Medical Care of the Aged—Areas of Needed Information." This was prepared by Mrs. Ida C. Merriam, Director, Division of Program Research.

September 13, 1960.—Meeting of group of State representatives to advise Bureau of Public Assistance on 1960 Medical Care Amendments. (Minutes dated September 21, 1960.)

September 15, 1960.—A letter from the Secretary, Department of Health, Education, and Welfare, to all Governors and others regarding the Social Security Act Amendments of 1960.

November 27, 1960.—American Medical Association Medical Services Conference on Federal-State medical care programs for the aged, Washington, D.C. Several papers on the background and status of title VI of Public Law 86–778 were presented, including one by Commissioner William L. Mitchell on "What We Can Do and Cannot Do Under the Law." (A summary of this speech was prepared for the record on July 5, 1961.)

April 20, 1961.—Summary information on State implementation of the Kerr-Mills bill.

July 14, 1961.—A statement from Miss Goodwin to Commissioner Ball on comments on statements on medical assistance to the aged being prepared for use in congressional hearings.

November 9, 1961.—Letter from Wilbur Cohen to Representative T. B. Curtis regarding medical assistance to the aged programs.

2. Publications

"The Social Security Amendments of 1960," Wilbur Cohen (published in Public Welfare, October 1960).

"Public Assistance," reprint from annual report, 1961.

"Report on Medical Care Under Public Assistance" (October 1960–61), to Ways and Means Committee, March 15, 1962.

"Characteristics of State Public Assistance Plans Under the Social Security Act," 1962, PA Report No. 49.

"Medical Aids for Older Persons Through Public Assistance" (questions and answers), BPA 1960.

"Activities of 54 Jurisdictions To Put MAA in Effect," October 31, 1960, December 20, 1960, and additional weekly reports on progress.

"Annual Statistical Report of Medical and Remedial Care Provided Through Public Assistance Vendor Payment," December 1960.

3. Technical medical consultation

Consultation in policy interpretation and ways and means of providing medical care for the aged has been held in each regional office and approximately half of the State departments of public welfare.

4. Institutes on medical care in which staff members participated

July 1961: University of Michigan, "Training Institute on the Administration of Medical Care for the Needy" (the Bureau was a cosponsor).

Region IX: San Francisco, February 1962, "Planning for Assistance To Accomplish Program Purposes."

Region IV: Atlanta, May 1962, "Administration of Medical Care Programs for the Needy."

5. Conferences and meetings

National Health Council, Miami, March 1960, "Health Care of the Aged and Role of Public Assistance Agencies in Working With the Ill Aged."

American Hospital Association:

"Provision of MAA and Their Relations to Hospitals," Chicago, September 1960.

"Workshops on Principles of Payment for Hospital Care," Chicago, March 1961.

"Medical Care of the Aging," Chicago, January 1962 (minutes dated March 20, 1962).

Annual Conference of Secretaries and Officers, California County Medical Society, Los Angeles, February 1962, panel, "Quality of Medical Care."

Southeast State and Territorial Health Officers, Gulfport, Miss., April 1962, "Joint Responsibilities and Relationship of State Health and Welfare Agencies in Developing Medical Care Standards for Welfare Recipients."

North Carolina Association of Nursing Homes and Homes for the Aged, April 1962.

American Public Health Association, Miami, October 1962.

American Hospital Association, Utilization of Hospitals for Aged, Chicago, October 1962.

National Council on Aging, moderator of panel on "Health" at seminar on "Protective Services for Older People," March 1963.

6. Papers presented by MCSD staff members

Alabama Public Health Association Medical Care Section, Mobile, March 1961, "Medical Care for the Aged."

"Services to Persons Needing Nursing Home Care," APWA region, Memphis, September 1961.

"The Viewpoint of Public Assistance," Institute on Financing Nursing Home Care, ANHA, Cleveland, September 1961.

APWA National Biennial Round Table Conference, Chicago, November 1962, "Medical Assistance for the Aged."

"The Medical Assistance for the Aged Programs," AMA, Denver, November 1961.

APWA, Southwest Region Conference, Dallas, March 1962, "Health Happiness in Old Age."

Annual meeting, Texas Society on Aging, November 1962, panel on "Vendor Medical Care for the Aged."

"Kerr-Mills in Action, 1962," AMA, Los Angeles, November 1962.

7. State letters regarding MAA program, March 1960–January 1963

Number	*State letter*
400	"Services to Older People," PA Report No. 38.
431	Social Security Amendments of 1960 (Public Law 86–778), implementation of law.
437	Public Law 86–778, Social Security Amendments of 1960, correction in attachment C to State letter No. 31.
451	"Medical Assistance for the Aged, Periodic Statistical Report," Form PA 204 and 233.
453	Bureau leaflet, "Medical Aid for Older Persons Through Public Assistance."
463	Handbook supplement, "Medical Assistance for the Aged."
466	"Public Assistance—1960," reprint from the annual report of the U.S. Department of Health, Education, and Welfare.
468.	Inquiry on implementation of Public Law 86–778.
469	"Medical Assistance for the Aged, Forms and Instructions for Submitting Estimates and Reporting Expenditures."
486	"Medical Assistance for the Aged, Financial Eligibility."
501	"Casework With the Aging," a reprint.
504	"Financial Eligibility: Medical Assistance for the Aged."
518	Institutional status.
525	Publication: "Public Assistance Under the Social Security Act," revised edition.
531	Handbook supplement, "Medical Assistance for the Aged."
532	"Home Health Aid Services—Vendor Payment for Medical Care."
556	"Characteristics of State Public Assistance Plans Under the Social Security Act: Provisions for Medical and Remedial Care," PA Report No. 9.
561	Report: "Medical Care Under Public Assistance" (March 15, 1962, report to Congress).
564	Publication: "Casework Services in Public Assistance Medical Care."
571	"Assistance to Individuals on Conditional Release From Mental Institutions," titles I (OAA and MAA), X, and XIV.
578	"Cost Estimates for Program of MAA."
584	"Public Assistance—1961," reprint from the annual report of U.S. Department of Health, Education, and Welfare.
593	"Forty-two-Day Provision Regarding Persons in a Mental Institution as a Result of a Diagnosis of Tuberculosis or Psychosis," title I, OAA and MAA.
603	Reports: "Cooperative Action Between State and Local Health and Welfare Agencies."

616 "Aid to the Aged, Blind, or Disabled, or Such Aid to Medical Assistance for the Aged," title XVI.
617 New title XVI: "Aid to the Aged, Blind, or Disabled, or for Such Aid and MAA," supplementary information for submittal of State plans.

Source: Prepared statement submitted by Secretary Celebrezze, at hearings held by subcommittee of the Committee on Appropriations of the House of Representatives, to consider his Department's budget for fiscal 1964.

Appendix B

Federal Percentage and Federal Medical Percentage for Old-Age Assistance and Medical Assistance for the Aged, by Jurisdiction

State	July 1, 1961, to June 30, 1963		July 1, 1963, to June 30, 1965	
	Federal percentage	Federal medical percentage	Federal percentage	Federal medical percentage
Alabama	65.00	79.04	65.00	78.29
Alaska	50.00	50.00	50.00	50.00
Arizona	58.39	58.39	58.75	58.75
Arkansas	65.00	80.00	65.00	80.00
California	50.00	50.00	50.00	50.00
Colorado	52.78	52.78	50.00	50.00
Connecticut	50.00	50.00	50.00	50.00
Delaware	50.00	50.00	50.00	50.00
District of Columbia	50.00	50.00	50.00	50.00
Florida	58.44	58.44	60.69	60.69
Georgia	65.00	75.04	65.00	73.69
Hawaii	53.38	53.38	50.00	50.00
Idaho	65.00	66.29	65.00	67.43
Illinois	50.00	50.00	50.00	50.00
Indiana	52.03	52.03	52.06	52.06
Iowa	58.48	58.48	57.63	57.63
Kansas	57.52	57.52	56.63	56.63
Kentucky	65.00	75.57	65.00	75.27
Louisiana	65.00	72.55	65.00	73.46
Maine	65.00	66.60	65.00	65.65
Maryland	50.00	50.00	50.00	50.00
Massachusetts	50.00	50.00	50.00	50.00
Michigan	50.00	50.00	50.00	50.00
Minnesota	57.96	57.96	56.42	56.42
Mississippi	65.00	80.00	65.00	80.00
Missouri	52.91	52.91	50.45	50.45
Montana	55.74	55.74	59.69	59.69
Nebraska	56.86	56.86	55.10	55.10
Nevada	50.00	50.00	50.00	50.00
New Hampshire	58.18	58.18	56.38	56.38
New Jersey	50.00	50.00	50.00	50.00
New Mexico	65.00	65.22	65.00	66.55
New York	50.00	50.00	50.00	50.00
North Carolina	65.00	77.47	65.00	74.99
North Dakota	65.00	72.44	65.00	73.03
Ohio	50.00	50.00	50.00	50.00
Oklahoma	65.00	66.53	65.00	65.65
Oregon	52.40	52.40	50.00	50.00
Pennsylvania	50.00	50.00	50.00	50.00
Rhode Island	51.09	51.09	50.90	50.90
South Carolina	65.00	80.00	65.00	80.00
South Dakota	65.00	72.16	65.00	68.87
Tennessee	65.00	75.87	65.00	75.53
Texas	60.79	60.79	61.45	61.45
Utah	63.74	63.74	62.28	62.28
Vermont	65.00	67.07	64.75	64.75
Virginia	64.91	64.91	65.00	65.05
Washington	50.00	50.00	50.00	50.00
West Virginia	65.00	70.32	65.00	71.76
Wisconsin	53.10	53.10	52.50	52.50
Wyoming	50.86	50.86	50.00	50.00
Guam	----------	50.00	----------	50.00
Puerto Rico	----------	50.00	----------	50.00
Virgin Islands	----------	50.00	----------	50.00

Appendix C

Estimated Population Aged 65 and Over Having Incomes of Less Than $2,000, Number of Medical Assistance for the Aged Recipients, and Number of Recipients per 1,000 Population Aged 65 and Over Having Incomes of Less Than $2,000, by Jurisdiction, 28 Jurisdictions Having MAA Programs, December 1962

Jurisdiction	Estimated number of aged population with no income or annual income of less than $2,000, Jan. 1, 1963	Medical assistance for the aged recipients, December 1962	Number of recipients per 1,000 population aged 65 and over having incomes of less than $2,000
Total, 28 jurisdictions	[1] 7,610,000	109,815	[1] 14.4
Alabama	244,000	254	1.0
Arkansas	180,000	1,959	10.9
California	1,047,000	15,885	15.2
Connecticut	169,000	4,536	26.8
Guam	[2]	88	[2]
Hawaii	27,000	546	20.2
Idaho	45,000	1,342	29.8
Illinois	706,000	858	1.2
Kentucky	252,000	2,583	10.3
Louisiana	208,000	313	1.5
Maine	84,000	248	3.0
Maryland	170,000	6,177	36.3
Massachusetts	411,000	21,830	53.1
Michigan	493,000	4,954	10.0
New Hampshire	52,000	106	2.0
New York	1,273,000	29,151	22.9
North Dakota	46,000	895	19.5
Oklahoma	221,000	553	2.5
Oregon	146,000	510	3.5
Pennsylvania	867,000	5,318	6.1
Puerto Rico	123,000	1,082	8.8
South Carolina	136,000	587	4.3
Tennessee	275,000	946	3.4
Utah	50,000	1,537	30.7
Vermont	34,000	59	1.7
Virgin Islands	[2]	479	[2]
Washington	216,000	848	3.9
West Virginia	135,000	6,171	45.7

[1] Does not include data for Guam and the Virgin Islands; basic data not yet available from Bureau of the Census.
[2] Not available; see footnote 1.

Appendix D

Summary of Kerr-Mills MAA Programs and OAA Programs

Provisions, by Jurisdiction, of Plans, June 1, 1963

ALABAMA

Aged in population (April 1, 1960), 261,000

Medical assistance for the aged

Program.—Legislation enacted in 1961, effective in 1962; service began February 1, 1962.

Eligibility.—Income: Net income in cash or readily negotiable resources may not exceed, for single person, $1,200 a year; for married couple, $1,800. (Excludes from considerarion income "in kind," e.g., food produced for home consumption.)

Assets: (1) Real property: House and land which is assessed as a homestead is exempt from consideration; other real property may be held if producing a net cash income. (2) Personal property excluded from consideration as available

to meet costs of medical care are personal belongings; tools and livestock used to produce food for home consumption; equipment, stocks of goods, tractor, truck, and similar property if used in a business to produce net cash income; $2,000 cash surrender value of life insurance. All other resources may not exceed a reserve of $1,000, single person or married couple living together. (Includes cash, bank accounts, stocks and bonds; idle tools, machinery, or livestock not used in producing food for home consumption or in a business; real property which is not producing a profit.) Benefits from health and hospital insurance policies will be taken into account in determining amount which can be paid from MAA program.

Person must be in need of hospital care to begin within 30 days of date of application.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospitalization limited to 15 days within a fiscal year; for acute illness or major injury. For elective cataract surgery or for diagnosed cancer only if treatment is not available from some other sources.

Physicians' services: Medical doctor or osteopath, a maximum of $15 for routine office calls, after each period of hospitalization if made within 30 days following patient's discharge from a period of hospital care; must be directly or indirectly related to the hospitalization.

Additional provisions.—Eligibility for MAA, once determined, continues for a 12-month period unless there is some known change in eligibility status.

Old-age assistance

Program.—During 1961 began vendor payments for nursing home care for OAA recipients (previously provided through the money payment and subject to maximums on such payments, including subsistence), initiated hospital care and limited physicians' services similar to those available under MAA.

Lien and recovery.—No provision.

Relative responsibility.—Ability of relatives to support is determined in each individual case (no State legislation prescribing such responsibility); if relative claims the applicant as a dependent for income tax purposes, he is presumed to be responsible for providing "more than one-half" of the support of such applicant.

Residence requirement.—One year immediately preceding application.

Scope of medical care provided.—Vendor payments are made for hospital care for acute illness and major injury up to 30 days per fiscal year; nursing home care; and physicians' services (medical doctor or osteopath) in office, home, or nursing home during a period not to exceed 30 days following patient's discharge from hospital care, for conditions related to hospitalization. Within the money payment which includes subsistence items, an amount may be budgeted for special nursing care in the recipient's place of residence other than a medical institution.

Money payment to recipient.—Administrative maximum on money payment to recipient is $75, based on a legal maximum in terms of amount of Federal matching of State expenditures.

ARKANSAS

Aged in population (April 1, 1960), 194,400

Medical assistance for the aged

Program.—Services began in September 1961 following an appropriation for the program made by the 1961 legislature.

Eligibility.—Income: Cash income for single person not to exceed $1,200 annually; for family, $1,500.

Assets: (1) Real property: May have home or an equity in home not to exceed $7,500. Value of other real property must come under the maximum on personal property. (2) Personal property, including value of nonhome real estate, livestock, motor vehicle, tools, equipment, and cash surrender value of life insurance. Household furnishings are excluded. Applicant may have a cash reserve up to $300 for one person and an additional $300 for dependents, with a family maximum of $600. Total value of all other property and resources may not exceed $2,500.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care limited to 30 days within a fiscal year, 60 days for cancer or first-, second-, or third-degree burns; nursing home care as recommended by physician; physicians' services in office or clinic only; services of ophthalmologist for treatment of eye conditions including surgery; dental care. Drugs not provided.

Additional provisions.—Need for medical care is determined concurrently with eligibility; when additional service is needed, review or reapplication is required; not applicable to persons receiving continuing care, whose cases are reviewed annually.

Old-age assistance

Program.—Since September 1960, added to scope of medical care for which vendor payments are made: dental care, statewide clinic services. Prescribed drugs provided through clinics or to patients in nursing homes, are included for some months, then withdrawn from vendor payment plan.

Lien and recovery.—No provision.

Relative responsibility.—Ability of relative to contribute to support of applicant is determined in accordance with a combined family income scale. However, a relative who claims an applicant (or recipient) as a dependent for income tax purposes is expected to be contributing $300 a year toward his support.

Residence requirement.—Legal: 3 years during the 5 years immediately preceding application, with last 1 year continuously. Or, by administrative interpretation: 5 years of the past 9 years immediately preceding application with 1 year immediately preceding application.

Scope of medical care provided.—Vendor payments are made for hospital care as certified by physician, up to 30 days a year; 60 days for cancer or first, second, or third degree burns; nursing home care; physicians' services in office or clinic only; services of ophthalmologist for treatment including surgery; dental care. Prescribed drugs up to $10 a month are provided within the money payment and subject to the State maximums.

Money payment to recipient.—Maximum of $70.

CALIFORNIA

Aged in population (April 1, 1960), 1,376,000

Medical assistance for the aged

Program.—Legislation enacted in 1961, effective January 1, 1962, provides basis for program. Services began in that month. Program is designed "to supplement the financial ability of counties to meet the health needs of aged persons."

Eligibility.—Income: Average monthly income over the next 12 months is not expected to exceed the cost of his medical care plus the cost of his maintenance as determined by the standard of assistance for old-age assistance. (Maximum standard for basic items and special needs is $171 a month.) If an individual is married, income is the combined separate income of the person plus his share of the "community income" of the couple.

Assets: (1) Real property: May have home owned and occupied. Value of other real property of applicant or applicant and spouse is limited to $5,000 assessed value less encumbrances if yielding a reasonable return which is used to meet needs. (2) Personal property limited to $1,200 less encumbrances, if single; if spouse also recipient, total is $2,000 less encumbrances; plus automobile needed for transportation with market value up to $1,500. Term includes net value of idle real property.

Eligibility is determined after an initial period of 30 days of hospital or nursing home care in a licensed medical institution, when physician estimates that such care will continue beyond 30 days. (Days may be cumulative if person is readmitted to a certified facility within 10 days of leaving such a facility.) Certification continues for a 12-month period. Holders of a valid certificate who require noninstitutional services may be certified for such services if eligible.

Recovery provisions.—No provision.

Relative responsibility.—No provision.

Deductible.—No deductible but MAA is not applicable until after initial period of 30 days of hospital or nursing care in a licensed medical institution. This provision applies to institutional and noninstitutional care. Hospital coverage available during first 30 days for care provided in county or county-contracted

facilities or for nursing home care upon transfer from such facilities. An individual incurring $2,000 of expenses for care while hospitalized may be covered from the time he exceeds the $2,000 deductible even if this occurs prior to the end of the initial 30-day period.

Scope of medical care provided.—Institutional care is available in hospital or licensed nursing home beginning after the first 30 days of care in such home, including all related services, inpatient physicians' calls and restorative and rehabilitative services; noninstitutional care is available after discharge from a period of institutional care and includes a full range of services including dental care, drugs, prosthetic applicances, physicians' services, rehabilitative services, diagnostic and therapeutic laboratory procedures, and home nursing care.

Additional provisions.—Eligibility for MAA once determined continues for a 12-month period and persons who require noninstitutional services may be certified for such services on the basis of the previously established 30-day period of hospital or nursing home care.

Old-age assistance

Program.—Added to the scope of medical care services dental care and home nursing; extended prescribed drugs and eye care.

Lien and recovery.—No provision.

Relative responsibility.—Ability of an adult child to contribute to support of parent is determined in relation to "relatives' contribution scale" based upon the net monthly income and number of dependents, beginning with $400 a month; allowance made for certain taxes and expenses of employment of such relative in computing his net income.

Residence requirement.—One year (immediately preceding application) and 5 of last 9 years (maximum requirement permitted by Federal law).

Scope of medical care provided.—Vendor payments are made for practitioners' services, dental care, and prescribed drugs. Other services, provided through the money payment to the recipient, are inpatient hospital care and nursing home care, both limited to the period prior to eligibility for MAA. Under specified circumstances, either vendor payment or money payment may be used to meet costs of sickroom supplies, home nursing care, X-rays, restorative and rehabilitative services, prosthetic appliances, equipment, and ambulance.

Money payment to recipient.—Maximum on money payment to recipient may be as high as $171 if the person has no other income and has certain "special needs" as defined by the State.

CONNECTICUT

Aged in population (April 1, 1960), 242,600

Medical assistance for the aged

Program.—State legislation authorizing a program of MAA was enacted in the 1961 session, to become effective April 15, 1962. The program was begun at that time.

Eligibility.—Income: All income is considered available to meet costs of medical care except: (1) Person receiving medical care but not resident in medical facility, if single, or married and not living with spouse, $1,550 a year, plus an amount not to exceed $150 if it is applied to payment of annual premium on personal health insurance; if married and living with spouse, $2,200, plus $250 if it is applied to payment of annual premium on personal health insurance. (2) Applicant receiving care in medical facility, spouse living outside such facility, $1,800 a year may be retained for the personal or other expenses of the spouse, plus $250 for annual premium if paid on personal health insurance of both spouses, or up to $150 if only one spouse is covered by such insurance.

Assets: (1) Real property: May own home; sale value of real property not used as a home, should be determined prior to certification of eligibility for MAA with provisions for exceptions under specified circumstances. (2) Personal property: Total may not exceed $900 for single person or if married and living apart from spouse; or $1,300 if married and living with spouse. Excluded from consideration is cash surrender value of insurance up to $500 for beneficiary, and $500 for spouse.

Medical benefits, which are available to applicant from sources such as personal health insurance plans, workman's compensation, Veterans' Administration, and private employee welfare programs, are primary resources for meeting

medical needs which must be utilized before determining extent or kinds of services to be paid for through MAA.

Recovery provisions.—Provision for filing claim by the State against the estate of the deceased recipient for the amount of assistance received; no recovery until after the death of a surviving spouse, if any.

Relative responsibility.—Extent to which a legally liable relative (spouse and adult children) is a financial resource is determined in accordance with agency policy (including a cost-of-living scale); the contribution finally determined as within the ability of the relative to provide is assumed to be available to the applicant.

Deductible.—Applicant is responsible for the first $100 of costs incurred for medical service for each calendar year; this will be waived for the recipient of OAA who is in a chronic or convalescent hospital, chronic disease hospital, or rest home with nursing supervision and is transferred to MAA. (Such medical service has been removed from scope of medical care provided under OAA.) The legislative session of 1963 is being asked by the State agency to rescind this requirement of first $100 of cost each calendar year to be paid by applicant.

Scope of medical care provided.—(1) Institutional care: Hospital care, general hospital including physicians' and surgeons' services; nursing home care as given in (*a*) chronic disease hospital, (*b*) convalescent hospital, (*c*) rest home with nurse supervision. (2) Noninstitutional care: Physicians' services, home, office, or within a medical facility; outpatient hospital and clinic services; visiting nurse services; prescribed drugs.

Recipient in medical facilities such as listed above under "nursing home care" may receive, in addition, dental care; sickroom supplies; prosthetic, surgical, and orthopedic appliances; eyeglasses; hearing aids; transportation; services of practitioners other than medical doctor, i.e., osteopath, optometrist, chiropractor, chiropodist (podiatrist), naturopath, or treatment of spiritual practitioner.

Nursing home care in the kinds of institutions specified has been withdrawn from the scope of OAA and transferred to MAA. Special provision is made to meet nonmedical budgeted needs (personal care and needs, and special needs, including health and life insurance premiums and temporary maintenance of rental facilities or own home) through State funds without Federal financial participation.

Additional provisions.—Eligibility is established concurrently with the need for medical care. The eligible applicant is given an identification card which certifies to his eligibility for medical care under the MAA program, but does not authorize payment for medical service bills for specific services. Reviewed in relation to the applicant's income available at that time to meet medical need, including insurance resources. For persons receiving long-term care, eligibility once established is reviewed annually and reapplication is not necessary.

Old-age assistance

Program.—Since September 1960, no significant change has been made in eligibility for or scope of the generally comprehensive medical care services available under OAA.

Lien and recovery.—State has preferred claim against estate, secured by lien against real property, to the extent that such estate is not needed for support of the surviving spouse, parent, or dependent children of the deceased recipient.

Relative responsibility.—Ability of adult children living outside the household to contribute to support and the amount of their contributions are determined in individual situations on the basis of the applicable cost of living scale and a specific responsibility factor. Needs of a self-supporting spouse residing outside the household are determined in accordance with public assistance standards plus certain additional allowances, income in excess of these needs is "budgeted as income available for support of the applicant."

Residence requirement.—No durational requirement. Must be resident at time of application.

Scope of medical care provided.—Vendor payments for costs of medical care are used for hospital care (prior to April 15, 1962, for nursing home care also), practitioners' services, dental care, prescribed drugs, nursing services in own home or in medical institution, restorative services, prosthetic appliances, transportation to secure medical care, and special equipment. Allowance is made in the money payment to recipient for premium for individually held hospital insurance policy, of Blue Cross or equivalent coverage and cost.

Money payment to recipient.—No maximum on money payment to recipient to meet total needs according to State's standard of assistance.

DISTRICT OF COLUMBIA

Aged in population (April 1, 1960), 69,100

Medical assistance for the aged

Program.—Services began during the first quarter of 1963 based upon provisions in an appropriation act in 1962 authorizing expenditure of funds for medical assistance to the aged.

Eligibility.—Income: May not exceed $175 per month for single person; family income not to exceed $200 for 2, $235 for 3, on up to $500 for 10 persons.

Assets: (1) Real property: Applicant may own homestead. Other real property "titled in the name of one or more members of the family group" renders applicant ineligible if owned outright, unencumbered, and refinanceable. If encumbered and meets one of the following terms, does not make person ineligible: (*a*) Any value, carrying two mortgages, not refinanceable; (*b*) value (determined by doubling assessed value) under $5,000, one mortgage, not refinanceable; (*c*) value (as above) $5,000–$10,000, 50 percent or more of first mortgage unpaid, not refinanceable; (*d*) value (as above) over $10,000, 75 percent or more of first mortgage unpaid, not refinanceable. (2) Personal property: Liquid assets not to exceed $500, excludes household furniture and clothing; personal property used in prosecution of a business, profession, or calling; or property "determined unavailable to pay for costs of hospital services."

Participation in costs: Person or his responsible representative must sign contract to meet terms of payment set after evaluation of ability to pay part of costs of needed care. No payment required if liquid assets are at or below $300, other resources not available, and monthly income is below minimum scale ranging from $150 for 1 person to $350 for 10 persons supported by family income. Liability for such payment in any one month for hospital services during the month shall not exceed the sum of (1) excess income over minimum scale, (2) excess of liquid assets over $300, and (3) other resources. Payments made by patient or others in his behalf are deducted from bills submitted.

Recovery provisions.—No provisions for recovery from estate of deceased recipient.

Relative responsibility.—No provision.

Deductible.—None; see "Participation in cost," above.

Scope of medical care provided.—Hospital inpatient and outpatient care in specified public and voluntary hospitals under contract to the Department of Public Health; District of Columbia Village Infirmary services; nursing services in the home by visiting nurse or public health nurse; home care for patients requiring continuing medical and nursing attention as available by home care service of Department of Public Health; transportation; appliances and prosthetic devices; drugs and biologicals not provided as part of inpatient, outpatient, or home care program, through pharmacies under contract with DPH; dental and podiatry services at clinics of DPH; home psychiatric services as available through the DPH; health maintenance services through centers of DPH.

Additional provisions.—Eligibility and need for medical care are determined concurrently.

Old-age assistance

Program.—Since September 1960 the District of Columbia has added hospitalization and home nursing to the scope of medical care.

Lien and recovery.—Amount of assistance plus 3 percent simple interest constitutes claim against estate (not secured by lien). Claim not enforceable against surviving spouse.

Relative responsibility.—Ability of legally responsible relatives (in OAA, children and grandchildren) living within the District of Columbia to contribute to support is computed in accordance with scales of income and number of dependents, with allowances made for taxes and certain defined family expenses.

Residence requirement.—One year immediately preceding application.

Scope of medical care provided.—Vendor payments for medical care are used for hospital care, in a hospital administered by or having a contract with the District of Columbia Department of Public Health, home calls by physicians under contract to the District of Columbia Department of Public Health, dental care, prescribed drugs other than those available without charge from the District of Columbia Pharmacy operated by the Department of Public Health; nursing care in own home from Visiting Nurse Association; sickroom supplies, prosthetic appliances; transportation, and special equipment; within the money payment, provision is

made for nursing home care; hospital outpatient treatment including emergency room service; nonemergency ambulance service.

Money payment to recipient.—No maximum on payment to recipient for assistance according to standards of agency.

GUAM

Aged in population (April 1, 1960) not available

Medical assistance for the aged

Program.—Legislation enacted in 1961; services under the program began February 1, 1962.

Eligibility.—Income: Annual income not to exceed $1,500 per annum for single person and $2,500 in case of a married applicant living with spouse.

Assets: (1) Real property: Used as a home or producing income of a value not to exceed $8,000. (2) Personal property: Holdings of a cash value not to exceed $800 if single, or $1,000 if married and living with spouse, exclusive of household effects and clothing used to meet current needs.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care, total hospital care in the civilian hospital, Guam Memorial; physicians' services, from the department of medical services when prescribed as critically necessary or for determining need of physicians' services; dental care, for relief of pain; prescribed drugs; ambulance, if other transportation cannot be used without hardship; prosthetic appliances.

Additional provisions.—Nursing home care is not included because there are no such institutions on the island. Eligibility for MAA and need for medical care are determined concurrently and subject to review if circumstances change.

Old-age assistance

Program.—In its 1961 session, the Guam legislative body made provision for vendor payment of costs of medical care for recipients of old-age assistance. Services were begun in February 1962.

Lien and recovery.—No provision.

Relative responsibility.—Ability of members of the same household as the applicant to provide support for him is determined for each individual case. (There is no legislation applicable to OAA which prescribes responsibility of relatives to support.)

Residence requirement.—No provision.

Scope of medical care provided.—Vendor payments for medical care are used for hospital care, physicians' services in home or at outpatient clinic when "critically necessary," dental care for relief of pain, prescribed drugs, prosthetic appliances, diagnostic services, and ambulance if other means of transportation cannot be used without hardship to patient.

Money payment to recipient.—No maximum on payment to meet total needs of recipient according to agency's standards of assistance.

HAWAII

Aged in population (April 1, 1960), 29,200

Medical assistance for the aged

Program.—Legislation enacted in 1961; services began July 1961.

Eligibility.—Income: Insufficient to meet the standards of assistance established for MAA, including nonmedical and medical requirements (approximately $50 per month above the standards of assistance of OAA) and if the resources available to him within 12 months after date of application are insufficient to pay the cost of needed medical care.

Assets: (1) Real property: Home with tax-appraised value of less than $14,000 is exempt; also other real property with value not to exceed $150. All excess value is considered a resource for payment of medical costs. (2) Personal property: All liquid assets beyond $50 cash savings (of unemancipated minor) are considered available after allowances for payments of obligations contracted for defined

essential purposes. May own automobile 4 years old or older or when necessary for essential transportation. Full loan value of life insurance is resource. Under exceptional circumstances, conservation of readily available resources allowed. Health insurance, Veterans Administration care, workmen's compensation, and similar resources must be taken into account in determining extent to which MAA is needed.

Recovery provisions.—No provision.

Relative responsibility.—An adult child is required by law to contribute to the extent of his financial ability, unless his parents failed to support him during his minority. Amount of contribution relative is expected to make is determined by a schedule, taking into account income and number of dependents.

Deductible.—None.

Scope of medical care provided.—Hospital care, nursing home care, practitioners' services, dental care, prescribed drugs, and outpatient and allied services.

Additional provisions.—Eligibility for assistance and need for medical care are determined concurently, taking into account resources available over the ensuing 12-month period which could be applied to costs of needed care. Annual review of persons needing continuing care, as in nursing homes; for other persons, eligibility and medical care are redetermined when additional service is needed or when circumstances of eligibility have changed.

Old-age assistance

Program.—Since September 1960, medical care through public assistance programs has been expanded to include persons otherwise eligible for OAA but in need of assistance only to meet costs of medical care.

Lien and recovery.—Claim, secured by lien, may be filed against estate of deceased recipient for amount of assistance granted; lien not enforcible against home while occupied by beneficiary, surviving unmarried spouse, minor or physically or mentally handicapped children. Recovery is permissive and not attempted if heirs are in need.

Relative responsibility.—An adult child is required by law to contribute to the extent of his financial ability, unless his parents failed to support him during his minority. Amount of contribution relative is expected to make is determined by a schedule, taking into account income and number of dependents.

Residence requirement.—No durational requirement; must be resident of State at time of application.

Scope of medical care provided.—Vendor payments are made for hospital care, physicians' services, dental care, prescribed drugs, sick-room supplies, X-rays, restorative services, prosthetic appliances, transportation to secure needed medical care, equipment, and, in exceptional cases where medically necessary, private duty nursing in hospital. Nursing home care is provided through MAA in defined situations or through the money payment. (In rural areas, physicians' services are provided by State government physician.)

Money payment to recipient.—To meet need according to State's standard of assistance; no maximum.

IDAHO

Aged in population (April 1, 1960), 58,300

Medical assistance for the aged

Program.—Legislation enacted in 1961; services began July 1, 1961.

Eligibility.—Income: Cash income from all sources is considered available to meet costs of medical care except for amount needed to meet "ordinary expenses and obligations" (calculated on basic requirements in State's "Standards of Assistance" plus $50 a month additional allowance to cover other obligations); in addition, for any month, one-twelfth of the savings and cash resources owned above $2,000 and less than $10,000 is considered available.

Assets: (1) Real property: May own home not excessive in value in relation to community standards. Value of other real property which can be made available is considered among cash assets. Total available assets—real and personal—may not exceed $10,000. (2) Personal property: Value of real property other than home plus personal property other than exclusions listed below may be held up to $2,000. Value in excess of this amount and under the maximum is considered available to meet costs of medical care, as stated in "Income,"

above. Excluded from assets available are household furniture and personal possessions of reasonable value, a "popular priced" car.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care for treatment of acute conditions, emergencies, contagious diseases, and nonelective surgery; nursing home care; practitioners' services. (Dental care and prescribed drugs are not provided through this program.)

Additional provisions.—Potential eligibility is determined concurrently with a "complaint of illness or injury" for which medical care is sought; actual eligibility is determined *after* medical care has been provided and is directly related to the costs of medical care incurred or predicted.

Old-age assistance

Program.—The first provision for vendor payment of medical care, beginning in January 1959, included only nursing home care. In 1960, hospitalization and physicians' services (and for a short period, prescribed drugs) were added to the program. As a result of legislation in 1961, all nursing home care was removed from OAA program and placed in scope of MAA, with due provision for meeting personal needs of patients who had no income other than assistance.

Lien and recovery.—Provision for signed agreement, to be recorded and thus constitute a lien for assistance received subsequent to July 1, 1951. Not enforced against property during life of owner except in case of sale of property, or as long as occupied as home by surviving spouse unless estate is probated.

Relative responsibility.—Determination of ability of relatives to contribute to support of applicant is part of investigation in each individual case.

Residence requirement.—One year immediately preceding application; reciprocal agreements may be made with other States.

Scope of medical care provided.—Vendor payments for hospital care, all usual services; physicians' services in home, hospital, office, or other appropriate place. (Dental care and prescribed care are not provided; nursing home care provided through MAA program.)

Money payment to recipient.—As needed according to State's standard of assistance; no maximum on payment.

ILLINOIS

Aged in population (April 10, 1960), 975,000

Medical assistance for the aged

Program.—Services began in September 1961; enabling legislation permits comprehensive scope of services but limitations of current appropriation required limiting services to hospital care, physicians' services in hospital, and physicians' services in posthospital period of home care.

Eligibility.—Income: After deducting amounts necessary to maintain in force a medical, surgical, hospital, or other health insurance; maximum gross income for single person, $1,800; for applicant and spouse or other dependent, $2,400; for applicant living with more than one dependent, $1,800 for applicant plus $600 for each dependent. Income includes contributions from responsible relatives.

Assets: (1) Real property: Value of property used as a home and contiguous real estate is excluded. (2) Personal property—i.e., "liquid or marketable assets"—may be held with value of not more than $1,800 for single person; $2,400 for applicant living with spouse or other dependent; $1,800 for applicant and $400 for each dependent when applicant has more than one dependent. Excluded in making this determination are clothing; personal effects; automobile; life insurance with a face value of $1,000 or less; and tangible personal property used in earning income with a fair market value of $1,000 or less.

Person is eligible for payment of costs that exceed 10 percent of his income or 10 percent of the combined income when he is living with a spouse or other dependent(s).

Recovery provisions.—Assistance received constitutes a claim against the estate of a deceased recipient.

Relative responsibility.—State plan provides for consideration of support from legally responsible relatives; i.e., spouses and adult children.

Deductible.—None required; see "Additional provisions" below.

Scope of medical care provided.—Hospital inpatient care for acute illness, accidental injury, surgery, chronic conditions requiring limited period of hospital care, or for diagnostic procedures that can be carried out only in hospital; physicians' services in hospital; during 30-day period following release from a hospital, physicians' services in patient's home or doctor's office. (Scope does not include nursing home care, dental care, or prescribed drugs.)

Additional provisions.—MAA is not available unless cost of allowable medical care exceeds 10 percent of total income of applicant or of the combined income of applicant and dependents living with him; benefits from health or hospital insurance policies covering applicant may meet or be applied to this requirement. Eligibility is determined concurrently with or prior to need for medical care and application serves for a 12-month period during which requests for new medical services require only review of financial circumstances and costs of additional service needed.

Old-age assistance

Program.—No substantive change in eligibility requirements or comprehensive scope of services provided through vendor payment since September 1960.

Lien and recovery.—All assistance granted on and after January 1, 1962, constitutes lien on recipient's legal and equitable interests in real property, not enforcible against real property occupied as a homestead by surviving spouse or specified relatives. If person received assistance prior to January 1, 1962, and is not a recipient after that date, total of assistance paid constitutes a claim against estate; not enforcible under some conditions as affect enforcement of lien. (Formerly all assistance constituted an unsecured claim against the estate of recipient.)

Relative responsibility.—Ability of defined relatives living in separate household from recipient is determined by a Relatives' Contribution Guide; specified expenses in addition to personal allowances are taken into account in determining contribution expected from the relative.

Residence requirement.—One year immediately preceding application, or if moved to Illinois within 5 years prior to application, must meet resident requirement of the other State. This period may not be less than 1 year nor more than 5 out of the last 9 years immediately preceding application.

Scope of medical care provided.—Vendor payments made for comprehensive scope of medical services: Hospital care, practitioners' services, dental care, prescribed drugs, sickroom supplies, diagnostic and therapeutic X–ray, prosthetic appliances, special equipment, services of Visiting Nurse Association. Nursing home care is provided through a combination of the money payment to recipient and vendor payment to the home as medical care.

Money payment to recipient.—No maximum on money payment to recipient for subsistence needs as defined by State.

KENTUCKY

Aged in population (April 1, 1960), 292,300

Medical assistance for the aged

Program.—Developed at the same time as first vendor payments for medical care in categorical public assistance programs; legislation enacted in a special session in 1960, effective January 1, 1961.

Eligibility.—Income: Annual gross income for single person may not exceed $1,200; for couple, $1,800. Special provisions for determining income from self-employment or from farming operations.

Assets: (1) Real property: Homestead is not considered; the equity in non-homestead real property may not exceed $5,000, single person or married couple. (2) Personal property limited to $750 for single person, $1,000 for applicant and spouse; excluding cash surrender value of life insurance not to exceed $3,000. (Personal property is defined as "cash on hand, money in bank, stocks, bonds, and other resources that can be converted into liquid assets"; excluded from consideration is cash surrender value of insurance within the maximum stated and tangible personal property not listed in definition.) Availability of health insurance is to be determined and evaluated.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care for acute, emergency, and life-endangering conditions up to 10 days per admission with no limit on number or frequency of admissions; physicians' services; nursing home care; dental care; prescribed drugs.

Additional provisions.—After eligibility for medical care is established, additional services may be secured within a 12-month period without additional application unless there has been a change in circumstances affecting eligibility.

Old-age assistance

Program.—Legislation in 1960 regular session authorized payments in behalf of recipients of public assistance for medical care; services began in January 1961; subsequently expanded.

Lien and recovery.—No provision.

Relative responsibility.—Ability of adult children to support is determined according to an income exemption scale, based on amount of income and number of dependents of such children; in determining amount considered available for support of parent, allowances are made for unusual family medical expenses which are deductible from Federal income tax.

Residence requirements.—6 months immediately preceding application.

Scope of medical care provided.—Vendor payments for medical care are made for hospital care for acute, emergency, and life-endangering conditions up to 6 days per admission with no limit on number or frequency of admissions; nursing home care; physicians' services; dental care; prescribed drugs. Nursing care in own home is budgeted within the money payment to the recipient and subject to the maximums on the money payment.

Money payment to recipient.—For subsistence needs, maximum of $85 per month.

LOUISIANA

Aged in population (April 1, 1960), 241,600

Medical assistance for the aged

Program.—Services began in November 1961, upon authorization of legislation enacted by State in regular session, 1961.

Eligibility.—Income: Income in excess of maximum allowable monthly income of $250 for single person or $325 for couple disqualifies; income less than this amount but in excess of (1) basic income and (2) allowable increases, as defined below, must be applied to costs of needed hospital care. (1) Basic income, $125 single, $175 married couple, combined income. (2) Allowable increases, $30 per month for each dependent minor child or disabled adult declared as dependent on applicant's income tax return; $15 additional income allowable for single person with hospitalization insurance, $25 for couple with such insurance.

Assets: (1) Real property: May own home as defined for homestead tax exemption; other real property not to exceed $5,000 assessed value if income producing or $1,000 value if not income producing; excess value is considered a liquid asset. (2) Personal property: Liquid assets not to exceed $1,000 for single, $1,500 for couple; excluding insurance with cash or loan value up to $1,500 (couple $2,000), motor vehicle used for transportation, farm equipment or business assets which are income producing. Excess value of insurance, car, or nonhome real property must come under the liquid assets maximum. Free resources for medical care, available from other than State facilities, must be used if possible without undue hardship. Medical insurance carried by applicant must be utilized fully and must be assigned to hospital before MAA is used; amounts thus paid toward hospital costs considered participation.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—Hospital care only: Patients with a monthly income over $90 ($140 for couple) participate in payment of the first $50 of costs when the costs exceed $10; the amount of participation (within this $50) is based on a sliding scale applied to available income. Amounts received from hospital insurance are considered as participation in determining amount to be paid before MAA may be applied to costs of hospital care. Such medical insurance must be utilized fully.

Scope of medical care provided.—Hospital care, including surgeons and attending physicians; nursing home care in licensed homes; medical doctor, for patients with an approved medical care plan covering serious continuing illness requiring care

for relief of severe suffering or for correction or prevention of permanent impairment; prescribed drugs for patients in nursing home care. (Dental care not provided.)

Additional provisions.—Need for medical care is determined concurrently with eligibility; may be for noncontinuing care (less than 3 months), with reapplication if other care is needed, or continuing care, with eligibility redetermined annually unless there is a change in circumstances which affects eligibility or need for medical service.

Old-age assistance

Program.—Since September 1960, State has added hospital care for OAA and expanded physicians' services and drugs.

Lien and recovery.—No provision.

Relative responsibility.—Determination of ability of relatives to contribute to support is part of investigation of individual case.

Residence requirement.—Five of last nine years with one year immediately preceding application.

Scope of medical care provided.—Vendor payments are used for hospital care, including physicians' services in hospital; nursing home care in licensed nursing home; medical doctor for persons with an approved medical care plan covering serious continuing illness requiring care for relief of severe suffering or for correction or prevention of permanent impairment; prescribed drugs for patient in licensed nursing home. In addition, sickroom supplies, nursing care not in a medical institution, prosthetic appliances, transportation, and special equipment are provided by vendor payment or through the money payment to the recipient according to agency's defined limitations or regulations. (Dental care not provided.)

Money payment to recipients.—Maximum of $82 for one person, $76 for each of two or more old-age assistance recipients in same household. Maximum may be exceeded up to $105 for nursing care in own home or in facility not subject to license. (Vendor payment for licensed nursing home.)

MAINE

Aged in population (April 1, 1960), 106,500

Medical assistance for the aged

Program.—Legislation enacted in 1961 regular session; services under the program began in October 1961.

Eligibility.—Income: Annual income for single person, not to exceed $1,500; exemption of $600 additional for each dependent.

Assets: (1) Real property used as home is exempt; other real property may be held up to a value of $500 for single person, $800 for applicant and spouse; property in excess of these amounts disqualifies. (2) Personal property: Value of personal property used to produce income (livestock, tools, farm equipment) may not exceed $1,000 for single person, $1,500 for applicant and spouse; non-income-producing personal property may not exceed $500 for single or $800 for married couple.

Medical resources such as health insurance or workmen's compensation must be applied to cost of medical care before payment for balance from MAA. Voluntary payments by the individual or by others in his behalf toward costs of medical care encompassed in MAA will be treated in the same way.

Recovery provisions.—No provision.

Relative responsibility.—Contributions made by relatives taken into account in determining amount needed from MAA.

Deductible.—None.

Scope of medical care provided.—Hospital care for essential services for chronic, emergency, and acute conditions up to a total of 45 days within a fiscal year; comprehensive clinic care for patients with cardiac diseases, arthritis, circulatory and cardiovascular diseases, tumors, diabetes, or eye diseases that may result in loss of vision if not treated, includes services of specialists; transportation to secure comprehensive clinic care; home care by aid or visiting nurse as recommended by clinic physician and provided by recognized public or private agency.

Additional provisions.—Eligibility once established entitles recipient to defined services for a 12-month period unless changes in circumstances make person ineligible.

Old-age assistance

Program.—Medical services paid for through vendor payment included hospital care and nursing home care prior to September 1960; since that date, rates and quality standards for both types of services have been raised.

Lien and recovery.—State has unsecured claim against estate of deceased recipient for amounts paid as assistance.

Relative responsibility.—Ability of specified relatives to contribute is determined according to a standard table of income and number of dependents; allowances are made for taxes and special expenses of the relative in determining the amount he is expected to contribute. (In OAA, such relatives are spouse and adult children.)

Residence requirement.—One year immediately preceding application; reciprocal agreements made with selected States.

Scope of medical care provided.—Vendor payments are made for hospital care up to 45 days a year and for nursing home care.

Money payment to recipient.—Eighty dollars per month maximum may be exceeded for person receiving family care in licensed nursing home, chronic hospital, or boarding home licensed for family care. In addition, premium paid into pooled fund for medical care encompassed in plans for vendor payments to suppliers.

MARYLAND

Aged in population (April 1, 1960), 226,500

Medical assistance for the aged

Program.—State agency's contract with State health department was extended to include services to persons eligible for MAA; care began June 1, 1961.

Eligibility.—Income: Regular income not to exceed (1) in Baltimore City and 5 larger counties $1,140 for single person, $1,560 for applicant with 1 dependent, plus allowances for additional dependents; (2) in 18 other counties $1,080 for single person, $1,500 for applicant with 1 dependent. Income includes that of spouse or of any other person claimed as dependent. Scale of value for income in kind.

Assets: (1) Real property: Home is exempt; real property other than home is included in other resources convertible to cash. (2) Personal property: Resources in cash or convertible to cash (savings, insurance, real property other than the home) may not exceed $2,500 cash value. A person is ineligible who has any insurance or other benefit the terms of which provide for payment for the medical care items included in the plan.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care, practitioners' services, dental care, prescribed drugs, sickroom supplies, X-ray, physical therapy, minor surgery in private office facility or accident room, special medical care clinics, eyeglasses when prescribed following cataract surgery. (Nursing home care not provided.)

Additional provisions.—Eligibility is determined concurrently with or prior to need for medical care; on the basis of the certificate from the department of public welfare, the health department issues a medical care card valid for 1 year and is responsible for identifying need for and arranging for medical care. Annual reinvestigation by welfare department, or more often if circumstances change.

Old-age assistance

Program.—Since September 1960, added dental care to scope of medical care provided and began vendor payments for patients receiving nursing home type of care in certain chronic care hospitals.

Lien and recovery.—State has unsecured claim against estate for all assistance paid.

Relative responsibility.—Ability of children to contribute is determined with responsibility scales of income and number of dependents; allowances are made for extraordinary expenses in determining the amount the children are expected to contribute. (Does not apply to husband living apart from his wife; his ability to support and the amount is determined by court action.)

Residence requirement.—One year immediately preceding application; may be waived by reciprocal agreement with another State providing Federal matching is not affected.

Scope of medical care provided.—Vendor payments for medical care are used for hospital care, nursing home type of care in five chronic care hospitals, practitioners' services, dental care, prescribed drugs, sickroom supplies, X-rays, physical therapy, and eyeglasses. Nursing home care other than specified above is provided through the money payment to the recipient subject to State maximums on the money payment.

Money payment to recipient.—The State is divided into three areas according to the cost of shelter as determined in the State's standards of assistance; the maximum on the money payment is $190 a month, $200, or $210 depending upon the "shelter plan" applicable to the area in which the local agency is.

MASSACHUSETTS

Aged in population (April 1, 1960), 572,000

Program.—Plan became operative and first payments were made in November 1960; services began in October 1960.

In the first 4 months of operations, about 89 percent of the total individual MAA recipients (roughly 14,000 out of 16,000) were transferred from other public assistance programs as recipients needing and receiving long-term nursing home care. As of January 1962 (15 months of operation) about 61 percent of the total caseload opened consisted of transfers from other public assistance programs, mainly OAA (18,826 former OAA recipients among 30,478 cases).

Eligibility.—Income: (1) Receiving medical care in own home: If single, or if married and husband is applicant, $150 per month is excluded (if wife is applicant, $225 a month combined income), excess income considered available to apply to costs of medical care. (2) Receiving short-term medical care in a hospital, nursing home, or public medical institution: For single person or for spouse remaining at home, $150 a month is excluded; total income between $150 and $300 is considered available to be applied to medical costs for a period of 3 or 6 months based on amount of excess; income (for couple, combined income of husband and wife) in excess of $300 a month disqualifies. (3) Receiving long-term or permanent care in a hospital, nursing home, or public medical institution: Single person or one of a couple may retain $15 for personal needs; for spouse remaining at home, $150 a month is excluded from consideration; all income (for couple, combined income of husand and wife) in excess of this amount is applied to payment of medical care.

Assets.—(1) Real property: Ownership of home does not disqualify; ownership of any interest in other real estate disqualifies. (2) Personal property: Total may not exceed $2,000 for single person or if married and husband is the applicant; $3,000 if married and wife is applicant, including combined ownership of husband and wife.

Recovery provisions.—Action for recovery may be brought after the death of recipient and his surviving spouse, if any.

Relative responsibility.—Ability of children to contribute is evaluated; allowances made for unusual circumstances involving family obligations in determining amount such children are expected to contribute.

Deductible.—None required.

Scope of medical care provided.—Comprehensive care is provided, and the program pays for all of the cost in excess of the amount of recipient's income and resources which have been determined to be available to meet such costs.

Additional provisions.—For persons in institutional care who have less than $15 a month income, allowance for personal needs of recipient is made from State funds with no Federal participation.

Old-age assistance

Program.—No substantive change in eligibility requirements or comprehensive scope of services provided through vendor payments for medical care since October 1961 except that long-term nursing home care was removed from OAA medical services and placed within the scope of the new program of medical assistance for the aged. Special allowance is made from State funds for persons transferred thus from OAA to MAA and still in need of subsistence payments.

Lien or recovery.—Lien required on real estate, not enforcible if (1) market value at time of death and the cash surrender value of life insurance do not exceed $1,500, or (2) property is occupied by surviving spouse as a home.

Relative responsibility.—Ability of adult children to contribute is evaluated according to a scale of income and number of dependents; defined allowances are

made for unusual circumstances involving family obligations in determining the amount such children are expected to contribute.

Residence requirement.—One year immediately preceding application.

Scope of medical care provided.—Vendor payments made for comprehensive scope of medical care: Inpatient hospital care, short-term nursing home care, practitioners' services, dental care, prescribed drugs, nursing care in own home, sickroom supplies, restorative services, prosthetic appliances, transportation, and equipment.

Money payments to recipients.—No maximum on money payment to recipients for subsistence needs as defined by State.

MICHIGAN

Aged in population (April 1, 1960), 638,000

Medical assistance for the aged

Program.—Services began in October 1960; first payments in November 1960. Scope of services to be provided was enlarged in 1961 by the addition of nursing home care for a posthospital period and home nursing care. The maximum on permissible income was also raised.

Eligibility.—Income: Maximum annual income for single person (unmarried or not living with spouse) is $1,500; if married and living with spouse, not more than $2,500, including the annual income of the spouse. Income must include contributions which son, daughter, or estranged spouse should be making to applicant, according to agency standards or court determination, except that such contributions are not included in computing income during first 30 days of each separate period recipient is hospitalized.

Assets: (1) Real property: Value of property used as a home is excluded. Value of other real property must be included in limits on marketable assets specified below. (2) Personal property—i.e., liquid or marketable assets—may be held with value of not more than $1,500 for single person, $2,000 for married applicant and spouse. Excluded in making this determination are clothing and household effects, cash surrender value (not value of matured policies) of life insurance, and not to exceed $1,000 of fair market value of personal property used in earning income. All other property, real and personal, must be evaluated in determining eligibility under the $1,500 or $2,000 limitation specified.

Recovery provisions.—Filing of claim against estate of deceased recipient is permissive, not required; held in abeyance during lifetime of surviving spouse, if any.

Relative responsibility.—Contributions from legally responsible relatives (children and spouse) or contributions which they should be making to applicant according to agency standards of court determination are included in the income of the applicant; except that such contributions are not counted as income during the first 30 days of hospitalization.

Deductible.—None required.

Scope of medical care provided.—Hospital care, including diagnostic procedures which can be carried out only on an inpatient basis; nursing home care beginning within 30 days following hospitalization for an acute illness and continuing up to a maximum of 90 days in a 12-month period; practitioners' services; nursing care in home when recommended by physician; outpatient clinic services, including first aid, physical therapy, therapeutic radium and X-ray, and specified diagnostic procedures.

Additional provisions.—Eligibility is determined concurrently with need for medical care and eligible status continues for a period of 12 months, subject to review if circumstances change.

Old-age assistance

Program.—Scope of medical services broadened since September 1960 by addition of home nursing care services and physical examinations for each new applicant.

Lien and recovery.—Claim for reimbursement may be filed against estate for total assistance paid since October 11, 1947. Not secured.

Relative responsibility.—Ability of responsible relative is determined in accordance with detailed scales of income and number of dependents; allowances up to specified maximums are made for living costs and for unusual financial circumstances in the individual situation in determining the amount he is expected to contribute.

Residence requirement.—Five of last nine years with one year immediately preceding application; or if person is receiving assistance from another State reciprocal agreements are made on residence requirement.

Scope of medical care provided.—Vendor payments are made for hospital care, without limitation as to nature or amount of service, for physicians' inpatient hospital calls and for special nursing services in hospital or at home. Other services provided through the money payment (subject to the maximum reported below) are nursing home care, practitioners' services, dental care, prescribed drugs, X-rays, prosthetic appliances, and ambulance transportation.

Money payment to recipient.—Maximum on money payment to recipient for subsistence needs as defined in the State's standards is $80 a month or $90 for person receiving care in an approved convalescent home or approved county medical institution.

NEW HAMPSHIRE

Aged in population (April 1, 1960), 67,700

Medical assistance for the aged

Program.—Legislation enacted in 1961 provided the basis for the program; services began September 1, 1961.

Eligibility.—Income: Annual net income from all sources may not exceed $1,200 for single person, $1,800 for married couple living together; plus $600 allowed for support of each dependent child. If both members of a couple are in the same nursing or boarding home, they are considered as single individuals.

Assets: (1) Real property: Home owned and occupied by applicant is excluded. Also excluded is net equity in other real property up to $500 for one person, $800 for couple. Net equity beyond $500 but less than $4,500 for single person (beyond $800 but less than $4,800 for couple) does not disqualify if real property is income producing. (2) Personal property: May hold livestock and equipment used to earn income up to a net cash value of $1,500; net cash equity of all other personal property, including cash value of life insurance, may not exceed $500 for single person, $800 for married couple. All medical resources such as health insurance or workmen's compensation are taken into account in determining extent of need for MAA.

Recovery provisions.—Provision for recovery from estate of a recipient after his death and that of the surviving spouse.

Relative responsibility.—Ability of adult children to support parents is determined according to income scale, with provision for taking into account certain extra family expenses if they exist.

Deductible.—None.

Scope of medical care provided.—Hospital care as needed up to 12 days per admission, including payment to surgeon (no payment to physician for post-operative visits); medical doctor or osteopath for services in home or office, limited to 18 calls per fiscal year, for visits to patient in hospital, 14 per 30-day period; outpatient laboratory and X-ray services by hospital. (Eye care is excluded from the scope of this program because it is available through the sight conservation division of the same State agency that administers MAA and OAA.)

Additional provisions.—Eligibility and need for medical care are determined concurrently, with the need for medical care evidenced by statement of a physician; eligibility is reviewed as new service is needed or if circumstances of case change; redetermination of total eligibility required every 12 months.

Old-age assistance

Program.—No substantive change in eligibility or scope of services since September 1960; already provided comprehensive range of services with provisions for vendor payment of costs.

Lien and recovery.—Assistance paid constitutes by law a lien on estate of recipient and of spouse living with recipient; no recovery on real estate occupied by surviving spouse.

Relative responsibility.—Ability of relatives, whether legally liable or not, and amount of contribution available for support of applicant is determined as part of initial investigation in each individual case. (No prescribed scale of amounts expected as contributions.)

Residence requirement.—Five out of last nine years and one year immediately preceding application; reciprocal agreements may be made with other States.

Scope of medical care provided.—Vendor payments are used for hospital care; practitioners' services in home, office, hospital, or outpatient clinic (2 per month for chronic illness, 6 per month for acute illness with extension possible, and 14 per 30 days of hospital care); dental care; prescribed drugs; sickroom supplies; special nursing services; X-rays, prosthetic appliances; and special equipment. Provisions are made within the money payment to the recipient for nursing home care in private and public nursing homes and for transportation to receive medical care.

Money payment to recipient.—Maximum of $100 per month; $105 for persons eating regularly in restaurants; plus payment into pooled fund for medical care. Maximum may be exceeded to meet costs of nursing home care or of nursing care in own home in lieu of nursing home placement; may also be exceeded for special diets, telephone required by health condition, or for premiums on individually held Blue Cross hospital insurance policy if policy has been carried for 1 year at other than agency expense.

NEW YORK

Aged in population (April 1, 1960), 1,688,000

Medical assistance for the aged

Program.—Services began in April 1961. Within the first months of operation many persons classified as OAA recipients (primarily those receiving medical care only, i.e., not in need of subsistence payments) who were receiving nursing home care were transferred to MAA. Nursing home care as a service continues to be given in both the OAA and the MAA programs without distinction as to length of time such care is needed by a recipient.

Eligibility.—All income and resources shall be deemed available to meet costs of medical care except as follows: Income: (1) In medical or nursing institutions for chronic care, up to $10 a month for personal care items; annual premiums for health insurance policy up to $150 for single recipient or $250 for married recipient if policy covers spouse; if married, up to $1,800 a year for support of spouse, including any income of spouse. (2) Not in facility for chronic care, $1,800 for single applicant; $2 600 for married applicant living with spouse; health insurance policy premiums up to $150 per year for single recipient or $250 if married and policy includes spouse. (See "Reserves," below.)

Assets: (1) Real property: Home is exempt; other real property not used as home must be utilized to apply to costs of care. (2) Personal property: Clothing and household effects are exempt; may have life insurance with cash surrender value of not more than $500 (single person or couple). Insurance in excess of this amount and nonessential property must be utilized.

Cash reserve permitted for person not living in a medical facility: $900 for single person or $1,300 for married couple. If value of nonhome real estate, nonessential personal property, and excess insurance together with cash or liquid assets does not exceed this reserve limit, such resources need not be utilized and applied to costs of care.

Recovery provisions.—Provision for recovery from estate of deceased recipient after death of surviving spouse.

Relative responsibility.—Spouse, parents, and children are liable for payment of medical care insofar as they are found able to assist.

Deductible.—None required; eligibility is determined concurrently with need for medical care and in relation to the known or predictable extent and cost of such care. In cases of continuing care, eligibility factors reconsidered once in 6 months or oftener if indicated.

Scope of medical care provided.—Hospital care, nursing home care, services of medical doctor, osteopath, dentist, optometrist, podiatrist, dental care, prescribed drugs, sickroom supplies, special nursing services, physical therapy and related rehabilitation services, laboratory and X-ray, out-patient hospital and clinic, eyeglasses, dentures, and prosthetic appliances.

Additional provisions.—MAA services are part of plans for medical care developed by each local welfare district, based on State's manual and subject to approval of the State department of social welfare.

Old-age assistance

Program.—No substantive change in eligibility or in comprehensive scope of medical care provided since September 1960 except that "medical care only cases" formerly served through OAA are generally eligible for new MAA programs.

Lien and recovery.—Local public welfare official may recover amount of assistance granted from recipient or his estate. Such claim may be secured by deed, mortgage, or lien with respect to real property; by assignment of or preferred claim against insurance; by assignment of other assets.

Relative responsibility.—Ability of responsible relatives to contribute is determined through a budgeting system, taking into account circumstances of the individual situation.

Residence requirement.—No durational requirement. Must be resident of State at time of application.

Scope of medical care provided.—The welfare district elects whether to use the money payment method or vendor payment method to meet costs of medical care. Services included are: hospital care, nursing home care (may use a combination of money and vendor payments), practitioners' services, dental care, prescribed drugs, sickroom supplies, special nursing services, X-rays, restorative services, prosthetic appliances, transportation, and equipment.

Money payment to recipient.—No maximum on money payment to recipient to meet subsistence needs defined by State plan.

NORTH DAKOTA

Aged in population (April 1, 1960), 58,600

Medical assistance for the aged

Program.—Legislation enacted in 1961 authorizes a program comparable in scope and content to the services available to recipients of old-age assistance. Services began July 1, 1961.

Eligibility.—Income: Annual income in excess of the following is considered available to meet costs of medical care: Single person, $1,200; married couple, $1,800. Persons living in a nursing home or hospital: Single, $96; married couple, both in nursing home or hospital, $192; married couple, one in nursing home or hospital and the other not living in an institution, $1,296.

Assets: (1) Real property: Homestead is exempt (town: house and up to 2 acres of land; rural: 160 acres contiguous to house). Other real property that is salable or in which applicant has an equity must be utilized to apply to medical care costs. (2) Personal property: Total value not to exceed $2,500, of which not more than $500 for single or $1,000 for married couple may be in cash, stocks, or bonds. Cash value of insurance comes under total value maximum but not under liquid assets maximum. Excluded from consideration as personal property are household goods, wearing apparel, or personal effects.

Recovery provisions.—Preferred claim against estate of deceased recipient; not enforceable against property needed for support or comfort of spouse.

Relative responsibility.—Applies to MAA same principles as for OAA; i.e., ability of specified relatives (those legally liable) to contribute to support of applicant is determined for each individual case at time of initial investigation.

Deductible.—Applicant must have paid or have obligated himself to pay $50 for medical care during 12 months preceding the application; benefits from health or hospital insurance will be considered as meeting this requirement.

Scope of medical care provided.—Hospital care, nursing home care in licensed home or in hospital on monthly contract basis, practitioners' services, dental care, prescribed drugs, special nursing care, physical therapy, prosthetic appliances, outpatient hospital and clinic services, diagnostic screening and preventive services, X-ray and laboratory services, transportation, and special equipment.

Additional provisions.—Eligibility for assistance and need for medical care are determined concurrently. Redetermination of eligibility is made annually, subject to earlier review if circumstances change. Recipient is determined to be ineligible if during the 12-month period he has not received $50 or more medical-health services. (Compare requirement under "Deductible" entry above.)

Old-age assistance

Program.—No substantive change in eligibility or in scope of medical services provided since September 1960; State provides comprehensive services to recipients. (Before the beginning of the program of MAA, medical care through OAA program was available also to persons in need of medical care only, although not in need of money payment for subsistence needs.)

Lien and recovery.—Total amount of assistance granted is preferred claim against estate of deceased; not enforceable against real estate occupied by surviving spouse

or dependents nor against personal property necessary for their support, maintenance, or comfort.

Relative responsibility.—Ability of specified relatives to contribute to support of applicant is determined for each individual case at time of initial investigation. (Legally liable relatives are spouse, parents, and children.)

Residence requirement.—One year immediately preceding application or if eligible in another State, same period of residence in North Dakota as would be required in other State for person moving there from North Dakota.

Scope of medical care provided.—Vendor payments are used for hospital care, all general services, limited to 60 days; short-term nursing home care, up to 30 days (long-term care is provided through the MAA program); practitioners' services; dental care; prescribed drugs; special nursing care; physical therapy; prosthetic appliances; transportation; and equipment. If applicant has health insurance and if physical condition indicates probable need for the benefits, cost of premium payments for such individually held policy may be included in the money payment.

Money payment to recipient.—No maximum; assistance granted to meet need as defined in State's standard of assistance.

OKLAHOMA

Aged in population (April 1, 1960), 248,800

Medical assistance for the aged

Program.—Services began in October 1960, based on interpretation of existing State statutes.

Eligibility.—Income: Annual income, single person, up to $2,000; for man and wife, up to $3,000. Maximum may be exceeded up to $300 per year under specified conditions. Exempts the income required by legal dependents according to ADC standards.

Assets: (1) Real property: May have equity up to $8,000 in home owned and occupied as home (urban includes necessary lots; rural includes up to 40 acres of land). Equity above this amount and value of other real property are considered among "Other resources." Home to which recipient or spouse has no feasible plans to return is no longer considered eligible for exemption as home occupied by recipient. (2) Personal property: Maximum set for each of four kinds of property: (*a*) Insurance, single person, cash value of first $1,000 face value; married, cash value of first $2,000 face value; married, living together and having separate policies, cash value of first $1,000 face value for each; (*b*) equity in tools for earning a living, up to $1,500; (*c*) equity in small business which he operates, up to $2,500; (*d*) "Other resources" limited to $700 for single person or $1,000 for married couple, including cash, stocks, bonds, etc., automobiles, excess of value of items listed in (*a*) and (*b*) preceding, excess equity of home, or property of any kind which can be made available for use of recipient or spouse.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Inpatient hospital care is limited to that necessary for treatment of life-endangering or sight-endangering conditions. Program provides for hospital care, medical care portion of nursing home care, with recipient responsible for room-board portion and personal needs; physicians' services, including those of surgeons and specialists; dental care in a licensed general hospital by oral surgeon for life-endangering conditions involving fractures, infections, or tumors of the mouth; nursing care in own home; for hospitalized patient, transportation and blood in some situations.

Additional provisions.—Eligibility is determined concurrently with need for medical care within the definition of the program as evidenced by statement of medical or osteopathic physician. Redetermination of eligibility is made whenever warranted by change in circumstances.

Old-age assistance

Program.—Since September 1960, State has expended hospitalization and physicians' services for old-age assistance recipients.

Lien and recovery.—No provision.

Relative responsibility.—No legal liability of relatives, but ability and willingness of relatives to contribute to support is evaluated in each individual case. If a

relative is claiming applicant as a dependent for income tax purposes, "it will be considered that he is meeting at least one-half" of the applicant's needs unless it is established that the income is not available for the use of the applicant.

Residence requirement.—Five out of last nine years, with one year immediately preceding application.

Scope of medical care provided.—Vendor payments are used for hospital care; for life-endangering or sight-endangering conditions; medical care portion of nursing home care costs, with the money payment to the recipient for the room-board portion and personal care items if needed; practitioners' services in home, nursing home, hospital, and outpatient clinic; dental care by oral surgeon in a general hospital for treatment of life-endangering conditions involving fractures, infections, or tumors of the mouth; special nursing services in recipient's place of residence; X-rays for treatment of malignancies; and transportation. (Prescribed drugs not provided for old-age assistance.)

Money payment to recipient.—Maximum of $69 to $172 per month, based on shelter arrangement and number of persons in household.

OREGON

Aged in population (April 1, 1960), 183,700

Medical assistance for the aged

Program.—Legislation enacted in 1961 authorizes the MAA program: services began November 1, 1961.

Eligibility.—Income: Single person, less than $1,500; married, combined income of husband and wife less than $2,000. Where it is not possible to determine the income of an absent spouse, applicant is treated as a single person.

Assets: (1) Real property: Home used by applicant or legal dependents, exempt; value of other real property together with personal property may not exceed $5,000 fair market value. (2) Personal property: Excluded from consideration are 1 automobile; household furnishings; personal property holdings used in earning a living (clothing, tools, machinery, and other goods and equipment). All other property must come under maximum specified above. Liquid assets (cash or equivalent) shall be less than $1,500 for single person, $2,000 for couple. Excluded from consideration is cash surrender value of life insurance held by applicant not to exceed $1,000.

Recovery provisions.—Recovery provisions of law regarding claims against estates will apply after death of recipient and spouse.

Relative responsibility.—No requirement.

Deductible.—Applicable to hospital care: Patient pays $7.50 per day for first 10 days of care up to a maximum of $75 per year.

Applicable to any combination of physicians' services, X-rays, or laboratory procedures: Patient first pays $50 within a benefit year, then becomes eligible for MAA payments.

Private medical insurance policies may be utilized in the payment of such deductible amounts and must be utilized to the fullest extent possible as an offset before MAA benefits are payable. MAA and partial benefits supplement each other.

Scope of medical care provided.—Hospital care, up to 14 days per benefit year (patient pays $7.50 per day for first 10 days of care per year); nursing home care upon transfer from at least 1 day of hospital care (no deductible, but days based on 4 days of nursing home care for each of the unused days remaining from the 14 days of hospital entitlement per benefit year); practitioners' services; outpatient hospital care when the physician renders services as defined in the program.

Additional provisions.—Eligibility once established continues for a year, including additional medical services, unless circumstances of case affecting eligibility change.

Old-age assistance

Program.—No substantive change since September 1960 in eligibility or scope of medical care; State had comprehensive services at that time.

Lien and recovery.—Assistance paid constitutes an unsecured, prior claim against property or any interest therein belonging to estate of recipient except such portion as is being occupied as a home by the spouse, minor dependent child, or parent of deceased recipient.

Relative responsibility.—Statutory income scale indicates legal liability of specified relatives; State public welfare commission has authority to review detailed

circumstances of the relative and to accept a less amount as the contribution he is able to make. Voluntary contributions to meet costs of medical care may be offset against the amounts specified in the statute as support. Receipt of assistance constitutes, on the part of the recipient, consent for the State public welfare commission to take action to recover amounts granted as assistance if relatives in question refuse to support.

Residence requirement.—Five of last nine years with one year immediately preceding application.

Scope of medical care provided.—Vendor payments are made for hospital care, nursing home care, practitioners' services, dental care, prescribed drugs, sickroom supplies, special nursing services, X-rays, restorative services under exceptional circumstances, prosthetic appliances, transportation, and equipment.

Money payment to recipient.—No maximum on money payment to meet needs of recipient according to State's standard of assistance.

PENNSYLVANIA

Aged in population (Apr. 1, 1960), 1,129,000

Medical assistance for the aged

Program.—Enabling legislation was enacted in July 1961; State's plan was developed in the ensuing months and services began under the plan in January 1962.

Eligibility.—Income: All income is considered in determining eligibility for MAA or extent to which MAA is needed, except following: Annual income up to $1,500 for single person, $2,400 combined annual income of married couple, plus $500 for each minor or incompetent child living with and dependent upon applicant. For person receiving nursing home care in a public institution, all income is considered applicable to cost of such care except $5 per month to meet personal needs.

Assets: (1) Real property: Home is exempt; value of all other real property must come under maximums cited below. (2) Personal property: Value of all other real and personal property may not exceed $1,500 for single person or $2,400 for couple (exclusive of household furnishing, necessary automobile, cash surrender value of life insurance up to $500 for applicant and $500 for spouse, or tools, equipment, and stock necessary to obtain income unless the value of such possessions appears to be excessive. For persons in a public nursing home for up to 6 months of care, real and personal property may be held up to value of $1,500 (exclusions same as above); after 6 months of care, resources are reevaluated, exempting only such property up to value of $500 (exclusions same as above, except car no longer exempt). Benefits available from Blue Cross, other hospital, health, or accident insurance, or workmen's compensation are taken into account.

Recovery provisions.—Provisions for recovery from estate of recipient, after death of recipient and surviving spouse.

Relative responsibility.—Liability of children for costs of medical care of parents is established by statute.

Deductible.—None required.

Scope of medical care provided.—Ward care in hospitals limited to 60 days during a benefit period; posthospital care in home, i.e., uninterrupted continuation of inpatient hospital care under an approved home-hospital program; nursing care; nursing home care in an institution operated by a county authority.

Additional provisions.—Eligibility for MAA is determined concurrently with need for medical care and is related to a benefit period, i.e., a benefit period ends when the person has had 60 consecutive days after discharge from hospital without being inpatient in any hospital.

Old-age assistance

Program.—When the MAA program began in January 1962, the OAA program was expanded to include hospital care among services provided through vendor payment.

Lien and recovery.—Lien secures claim against property owner for all assistance paid to him or certain of his relatives; not enforcible against home or furnishings used by property owner, spouse, or dependent child.

Relative responsibility.—Ability of responsible relatives (spouse, parents, children) to support is determined in each case by a formula based on net income and number of dependents. Amount of such potential resource is considered available income of the applicant in determining extent of his need for assistance.

Residence requirement.—One year immediately prior to application, or was last a resident of State with which reciprocal agreement has been made to grant assistance without regard to period of residence. Must be residing in State at time of application.

Scope of medical care provided.—Vendor payments for medical care are used for hospital care, posthospital care in the home, practitioners' services, dental care, prescribed drugs, sickroom supplies, nursing services at home, X-rays, physical therapy, certain prosthetic appliances.

Money payment to recipient.—There is no maximum on the money payment to the recipient to meet subsistence needs as defined by the State.

PUERTO RICO

Aged in population (Apr. 1, 1960), 122,200

Medical assistance for the aged

Program.—Services began when Federal funds were made available for this program, October 1960. Division of public welfare is a part of the department of health, which already had responsibility for providing medical care to medically indigent persons. Arrangements were made to purchase from the health department facilities certain medical services for persons eligible for MAA.

Eligibility.—Income: Annual income and available liquid resources of individual may not exceed $1,500; and every couple living together whose individual annual income and available resources do not exceed $3,000.

Assets: (1) Real property: Home where applicant resides is excluded from consideration; all other real property is taken into account in determining eligibility. (2) Personal property: Loan value of life insurance and any other available resources will be taken into account. Membership in organizations which provide medical care or payment therefor make applicant ineligible.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care; nursing home care where available and as prescribed by physician; outpatient hospital care and dispensary services furnished through the facilities of the department of health and hospitals under contract, including physicians' services, prescribed drugs and appliances, physical therapy and related services, dental care, laboratory and X-ray services, and preventive medical care. (Practitioners' services, dental care, and prescribed drugs not provided except through such clinics.)

Additional provisions.—Eligibility is determined concurrently with or prior to the need for medical care and remains in effect for additional services during 1 year, subject to review if case circumstances change. Membership of applicant in such organizations as Blue Cross, Blue Shield, State retirement or compensation systems, applicant's purchase of health insurance of any appropriate type, his rights to veterans' benefits, and similar resources to provide or meet costs of medical care "shall make him ineligible for participation in" MAA.

Old-age assistance

Program.—Since September 1960, Commonwealth has begun vendor payments in behalf of OAA recipients for hospital care.

Lien and recovery.—No provision.

Relative responsibility.—Ability of specified relatives to contribute is determined through a budgeting procedure, taking into account the circumstances of the individual situation.

Residence requirement.—No durational residence requirement.

Scope of medical care provided.—Vendor payments are made for hospital care, including drugs prescribed while person is hospitalized and dental care which may be given during a period of hospital care. (Other medical services are available to recipients of OAA through the department of health program for medically indigent persons.)

Money payment to recipient.—No maximum on payment to meet needs of recipient according to agency's standards of assistance.

SOUTH CAROLINA

Aged in population (April 1, 1960), 150,600

Medical aid for the aged

Program.—Legislation was enacted in 1961 regular session authorizing the program; services were begun July 1, 1961.

Eligibility.—Income: Maximum annual income for single person is $1,300; for married couple, combined income may not exceed $2,100. In determining income from the operation of a business, net income will be considered.

Assets: (1) Real property: Home and land upon which it stands, owned and occupied by applicant or to which he has reasonable plans to return, is exempt as a resource. Other real property may be held if income producing; if nonincome producing, sale value of the property is considered under the income maximums. (2) Personal property: May hold (1) savings of $500 if single or $800 combined savings of married couple; (2) insurance with cash, loan, or surrender value of $1,000 for single person and of $2,000 for married couple. Savings in excess of the amounts specified above are considered under the maximum on income. Cash loan or surrender value of insurance in excess of amount specified is first added to the savings allowance up to the maximum and then considered under maximum income. Not considered as assets available for payment of medical care costs is value of such personal property as automobile needed for transportation, household furnishings, and farm equipment.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care for acute illness, injury, or condition that endangers sight when the need for hospitalization is essential, not to exceed 40 days of care in a fiscal year; nursing home care, following discharge from period of hospital care, generally limited to 90 days within a fiscal year but may be extended when required by such conditions as severe burns or terminal cancer; outpatient hospital or clinic services in organized clinic, including emergency room service, special diagnostic and therapeutic procedures, minor surgery such as biopsies. (Practitioners' services, dental care, and prescribed drugs not provided elsewhere.)

Additional provisions.—Eligibility is determined concurrently with need for medical care and redetermined as circumstances change or at least annually.

Old-age assistance

Program.—No substantive change in eligibility or scope of services provided in medical care since September 1960.

Lien and recovery.—Total amount of assistance paid since July 1, 1956, allowed as unsecured claim against estate on death of recipient. No recovery on real property used by dependent relatives nor when gross market value of estate is less than $500.

Relative responsibility.—Ability of close relatives, particularly children, to contribute is determined in each individual case. If relative claims applicant as a dependent for income tax purposes, he is expected to be contributing not less than 51 percent of the budgeted need of the applicant unless the relative in question has so many dependents in his own family that he is not liable for income tax and is unable to make a contribution.

Residence requirement.—One year immediately preceding application.

Scope of medical care provided.—Vendor payments are used for hospital care for acute injuries and illnesses, up to 40 days a fiscal year; and for nursing home care for a period of 90 days following discharge from a period of hospital care, with extensions for serious conditions requiring longer care. Money payments within the maximum on total payment, including subsistence needs, are used for prescribed drugs, home nursing services, and care in facilities other than post-hospital nursing home care.

Money payment to recipient.—Maximum, $70 a month.

TENNESSEE

Aged in population (April 1, 1960), 308,900

Medical assistance for the aged

Program.—Enabling legislation was enacted in 1961; program services began July 1, 1961.

Eligibility.—Income: Annual income not to exceed $1,000 for single person or $1,500 for couple. May also deduct the actual cost of support of totally dependent children. Any benefit designated specifically for support of such dependent child (for example, VA or SSA) residing in the applicant's home is excluded from income of applicant; but the amount of such benefit is subtracted from cost of support of the child to determine the amount to be considered as the exemption in the income of applicant.

Assets: (1) Real property: Equity in all real property (including the home) owned by applicant cannot exceed $8,000 if encumbered or $10,000 if unencumbered (figured on the county assessment percentage for the county in which the real property is located). (2) Personal property: Total of cash, savings, or items readily convertible into cash may not exceed $1,000 for single person or $1,500 for a couple, excluding cash value of life insurance up to $1,000 for single person or $1,500 a couple. Excess cash value must be considered under the liquid assets maximum. Health insurance benefits and contributions for medical care must be taken into account.

Recovery provisions.—No provision.

Relative responsibility.—No requirement.

Deductible.—For hospital care, MAA payments cannot be made until the person has incurred hospital expenses amounting to $25 within a fiscal year (either at one time or as a result of more than one admission to the hospital). MAA payment can begin the day after such amount accrues. Benefits from health or hospital insurance covering the applicant may be applied to meet this $25 prior to being considered available to meet costs of days of care for which MAA would be charged.

Scope of medical care provided.—All general services within definition of the program; i.e., for acute illness, injury, or life-endangering illness whether acute or not, requiring hospital care. Limited to 15 days per fiscal year. Payment for MAA not applicable until day after patient has incurred hospital expenses amounting to $25 during the fiscal year. Nursing home care in licensed and approved homes; upon recommendation of physician; 90 days per fiscal year. Drugs prescribed for treatment of diabetes, cardiac disease, and urinary tract infection.

Additional provisions.—Eligibility for MAA may be determined at time of or immediately prior to actual need for hospital care or for the drugs for treatment of conditions specified in the program definition. Certification may be up to the predictable date when such need is expected to end or may be for a period of 1 year, subject to review and redetermination when additional need for further medical care arises.

Old-age assistance

Program.—Since September 1960, State has extended services in hospital care and nursing home care for OAA recipients.

Lien and recovery.—No provision.

Relative responsibility.—No legislation prescribing support from relatives, but State's plan provides that the ability of specified relatives to contribute is evaluated in accordance with a scale of income and number of dependents, after allowance for taxes and special expenses. Where there is a true "surplus" of net income (after living and necessary work expenses, medical care, income taxes, social security taxes, retirement, and union dues) above the levels shown in the scale, a portion of this "surplus" shall be considered income available to applicant whether actually contributed or assumed to be contributed.

Residence requirement.—One year immediately preceding date of application.

Scope of medical care provided.—Vendor payments are used for hospital care for acute illness or injury up to a maximum of 30 days per fiscal year; nursing home care in licensed and approved homes. Provision may be made within the money payment for total needs, subject to State's maximum on such payment, for special nursing services not in a medical institution. (Practitioners' services, dental care, or prescribed drugs are not provided.)

Money payment to recipient.—Maximum on money payment, including all subsistence and special needs, $55 per month, or up to $60 for persons who require nursing care in own home or service for household tasks.

UTAH

Aged in population (April 1, 1960), 60,000

Medical assistance for the aged

Program.—Legislation in 1961 amended the State Public Assistance Act so as to authorize a program of medical assistance for the aged; services began July 1, 1961.

Eligibility.—Income: Net monthly income available may not exceed $125 for single person, $200 for two persons or couple.

Assets: (1) Real property: Home owned and occupied is excluded; net value of other real property is included in total allowable as available to meet costs of medical care needed. (2) Personal property: Net value of all property other than the home and excluded nonliquid assets defined below may not exceed $10,000. Negotiable or liquid assets available to meet costs of medical care may not exceed $1,000 for single, $2,000 for couple or family. Amounts in excess of these maximums must be applied to cost of major medical care before MAA may be granted to cover additional costs. Excluded from consideration as liquid assets are furniture, household equipment, livestock, implements, tools, and a necessary automobile. Health and hospital insurance will be applied on medical bills in determining amount of MAA needed.

Recovery provisions.—Medical assistance granted will constitute a preferred claim against the estate left by the recipient, after the death of recipient and surviving spouse, if any.

Relative responsibility.—Relatives are not legally responsible for the care and maintenance of a recipient but are required to contribute toward costs of medical care.

Deductible.—None.

Scope of medical care provided.—Hospital care, medical doctor, nursing home care in homes licensed by State health department; dental care; prescribed drugs; medical requisites, appliances, etc., and home health aid services.

Additional provisions.—Eligibility and need for medical care are established concurrently. Case which remains open is subject to annual review, or more frequent if circumstances warrant it.

Old-age assistance

Program.—Since September 1960, State extended nursing home care and added prescribed drugs to services provided.

Lien and recovery.—All real property or interest therein must be pledged as guarantee of assistance received. Settlement of liens not operative during lifetime of spouse and may be postponed indefinitely if heirs or devisees are recipients of public assistance.

Relative responsibility.—There is no legal liability of relatives to support. State's plan requires evaluating ability of relatives to contribute to cost of needed medical care.

Residence requirement.—One year immediately preceding application.

Scope of medical care provided.—Vendor payments are used for hospital care, up to 15 days per admission; nursing home care; medical doctor, dentist, optometrist, podiatrist, chiropractor or naturopath if no medical doctor within 45 miles; home, office hospital, outpatient calls; limited to four calls in 60 days for chronic conditions; dental care; prescribed drugs; sickroom supplies, X-rays, prosthetic appliances; transportation; and equipment.

Money payment to recipient.—Maximum on money payment to recipient, $80 for one person case, $128 for two-person case (additional allowances made for additional persons in case). Such maximums may be exceeded for "special circumstance items" specified in the State's standard of assistance.

VERMONT

Aged in population (Apr. 1, 1960), 43,700

Medical assistance for the aged

Program.—Legislation enacted in 1961 authorizing the program with actual operative date of the program to be set by executive order of the Governor. Because of limited appropriation, services began July 1, 1962.

Eligibility.—Income: Single person, limited to $1,500 annually; for married couple living in same household, $2,250 annually. Provision for allocation of $600 a year from individual or combined income for dependent children. Annual amount spent for health insurance may be exempted from net income before applying these maximums.

Assets: (1) Real property: Home owned and occupied by client or spouse is exempt. May have equity in property not used as home up to $2,500; equity in excess of that amount is considered within the maximums on personal property. (2) Personal property: May hold insurance with cash value of $1,500 per person. Savings, stocks, bonds, excess insurance value limited to equity of $600 for one person, $1,200 for married couple. Excluded from consideration is value of livestock, tools, machinery, household furnishings, personal effects, and an automobile used by client or spouse.

All medical resources must be taken into account. MAA will supplement health insurance, workmen's compensation, and other accident and health insurance up to the maximum allowable within the limited scope of hospitalization and physicians' services outlined.

Financial eligibility is determined concurrently with need for medical care which is presently existing or predictable in near future. A person who is once determined eligible may receive services in a 12-month period without additional application or review unless eligibility factors have changed.

Recovery provision.—No provision for recovery of assistance correctly paid either prior to or after death of recipient. Voluntary offers to repay shall be accepted.

Relative responsibility.—Legally liable relatives are expected to assume their legal and moral financial obligations to parents to the extent that they are capable; but no person shall be denied MAA because of unwillingness of legally liable relative to contribute.

Deductible.—Recipient must pay first $7 a day for first 14 days in each period of hospitalization and first six physician's calls in any calendar quarter.

Scope of medical care provided.—Hospitalization for essential care 14 days per admission, extensions possible with prior authorization; services of medical doctor or osteopath, limited to six home or office visits in any calendar quarter after recipient has paid for first six calls in the quarter. Dental care, prescribed drugs, and other care not provided.

Old-age assistance

Program.—Medical care services were expanded since September 1960 to include hospitalization and physicians' services. (Prior to that date, State had used vendor payments only for nursing home care.)

Lien and recovery.—Total amount of assistance received constitutes a statutory lien on estate of recipient. Not enforced against real estate occupied as a home by surviving spouse if spouse does not marry thereafter. Chattel mortgage taken on mobile home.

Relative responsibility.—Possibility of contribution from selected relatives who do not live in the same household with recipient, whether legally liable for his support or not, is determined in each individual case in accordance with defined public assistance standards.

Residence requirement.—Two of the past six years immediately preceding application.

Scope of medical care provided.—Vendor payments are used for costs of hospital care, nursing home care, practitioners' services up to 12 visits per calendar quarter, and special duty nursing service for hospitalized patient if included by hospital in list of standard ancillary charges. Within the money payment, subject to State's maximum, allowance may be made for dental care and other medical care needs.

Money payment to recipient.—Maximum for all needs, $80 per month.

VIRGIN ISLANDS

Aged in population (April 1, 1960), 2,200

Medical assistance for the aged

Program.—Legislation enacted in 1960, services began January 1, 1961; department of social welfare contracts with Insular Department of Health for medical aspects of the program.

Eligibility.—Income: Current continuing gross annual income of $1,200 or less for single persons; $2,400 for married couple living together.

Assets: (1) Real property: Total real property, including home owned and occupied, may not exceed $10,000. (2) Personal property: Cash assets, or those readily convertible into cash, may not exceed $1,200 for single person, $2,400 for married couple living together. Health insurance and "Government entitlement such as veterans medical services" are available assets which are taken into account in determining need for and extent of MAA.

Recovery provisions.—No provisions.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care, including private duty nursing service when prescribed as "critically necessary"; physicians' services to patients under home care program; dental care and prescribed drugs as provided through facilities of health department; prosthetic and other appliances; outpatient clinic services of health department.

Additional provisions.—Eligibility may be determined prior to specific or predictable need for medical care, and such prior enrollment remains in effect as long as the person remains eligible, subject to annual or more frequent reinvestigations.

Old-age assistance

Program.—Prior to September 1960, services for which vendor payments were made were limited to prescribed medicines and certain prosthetic appliances. Since that date, the program has been expanded to include hospitalization, physicians' services, and outpatient clinic care.

Lien and recovery.—No provision.

Relative responsibility.—Ability of specified relatives to contribute is determined on the basis of an income scale and certain percentages of the surplus income. Allowances are made for the number of dependents of the relative, certain taxes, and exceptional expenses which he has.

Residence requirement.—No durational residence requirement; must be resident of Virgin Islands at time of application.

Scope of medical care provided.—Vendor payments for medical care are used for hospital care, home visits of physicians to patients under the home care program, dental care, prescribed drugs, sick-room supplies, special nursing services, prosthetic appliances, X-rays, restorative services, transportation, and special equipment. (Nursing home care is not provided because facilities are not available on the islands.)

Money payment to recipient.—No maximum on money payment to meet needs of recipient according to department of social welfare standards of assistance.

WASHINGTON

Aged in population (April 1, 1960), 279,000

Medical assistance for the aged

Program.—Services began under the program in October 1960 based upon interpretation of provisions in existing State statutes.

Eligibility.—Income: Net income (cash or kind) regularly and predictably received by the applicant, the combined dollar value of which is in excess of that needed to meet his and his legal dependents' maintenance requirements as measured by the department's OAA standards of assistance, is considered as income available which must be applied toward meeting the cost of approved medical care.

Assets: (1) Real property: Home used by applicant or his legal dependents, together with reasonable amount of contiguous land, is not considered an available asset. Value of other real estate is included in total of assets available. (2) Per-

sonal property: All other resources and liquid assets, including cash surrender value of life insurance, are considered to determine extent to which they may be utilized for payment of needed medical care, except household furnishings and personal clothing, one automobile, and personal property "used and useful or of great sentimental value." Medical insurance in force at time of application and any potential compensation for injury must be utilized to the fullest extent.

Recovery provision.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—All services are limited to essential care for emergent or acute medical conditions, with exceptions being granted when supported by adequate medical justification. Within this definition, program provides hospital care; nursing home care; practitioners' services; dental care for relief of pain, cost not to exceed $25; prescribed drugs; special nursing services; X-rays, physical therapy, prosthetic appliances; transportation; equipment; and outpatient clinic care.

Additional provisions.—Need for medical care is determined on the basis of recommendations submitted by the patient's attending physician, subject to screening and approval by the State department of public assistance, and financial need is based upon current resources in relation to the estimated cost of such essential medical care. Eligibility is certified for a single ailment or condition and subject to monthly review. New certification is required if new need arises after a previous period of medical service has been terminated.

Old-age assistance

Program.—Since September 1960, the State has extended prescribed drugs and dental care in the public assistance medical care services.

Lien and recovery.—No provision.

Relative responsibility.—Ability and willingness of relatives to contribute to support is determined for each individual case, taking into account such contributions when available.

Residence requirement.—Five out of last nine years including one continuous year immediately preceding application.

Scope of medical care provided.—(Definition in statute includes "needed medical, dental, and allied services. * * *") Vendor payments to suppliers are made for hospital care, nursing home care in licensed homes, practitioners' services, acute or emergent, dental care not to exceed $25 in cost, prescribed drugs, special nursing services, X-rays, physical therapy, prosthetic appliances, transportation, and equipment. Nursing home care in home not subject to license is provided through the money payment to the recipient.

Money payment to recipient.—Maximum per month for any assistance unit is $325.

WEST VIRGINIA

Aged in population (April 1, 1960), 172,500

Medical assistance for the aged

Program.—Legislation enacted at a special session in October 1960; services began within the same month.

Eligibility.—Income: For single individual, $1,500 or less per year; person married and living with spouse, combined income of both is $3,000 or less. Income includes contributions received from relatives.

Assets: (1) Real property: Assessed value of all real property, including homestead, may not exceed $4,000. (2) Personal property or other liquid or marketable assets, including cash surrender value of life insurance, may not exceed $1,000 for single person, $1,500 for combined assets of husband and wife. Excluded from consideration as liquid assets are clothing and personal effects, household furnishings, and an automobile.

Benefits available from commercial health insurance are taken into account in determining amount of and kind of service needed from MAA.

Recovery provision.—No provision.

Relative responsibility.—No requirement.

Deductible.—None.

Scope of medical care provided.—Hospital care limited to 12 days per fiscal year, for acute illness or immediate surgery; nursing home care after a period of hospital care or if such care would prevent need for hospital care, acute conditions only; practitioners' services related to acute and life-endangering conditions; emergency dental care; prescribed drugs for eight specified chronic conditions; and such other services available to OAA recipients as are related to treatment of acute conditions. (No provisions for the services classed as "remedial care.")

Additional provisions.—Eligibility is determined concurrently with need for medical care as evidenced by a statement of the attending physician. (Former provision for enrollment, if financially eligible, prior to need for medical care has been rescinded.) Once established, eligibility remains in effect for 1 year subject to review if circumstances change.

Old-age assistance

Program.—Since September 1960, medical services have been expanded by extension of list of chronic conditions for which drugs are provided.

Lien and recovery.—State takes lien against real property in excess of $1,500 and against personal property in excess of $200; such lien applicable to estate after death and during lifetime; not enforced against real estate occupied by surviving spouse unless remarries or there is threatened or actual sale or transfer of the property.

Relative responsibility.—Ability of legally responsible relative to contribute to support is determined in accordance with a standard income schedule, which makes allowances for number of dependents, certain taxes, and for other specified expenses. Surplus income of relative living in a household separate from that of applicant is not considered available to applicant unless the relative is actually making a contribution or has expressed a willingness to contribute a specific amount regularly.

Residence requirement.—One year immediately preceding application.

Scope of medical care provided.—Vendor payments are used for hospital care for emergency medical and surgical services up to 30 days per fiscal year (for remedial care, time is extended); practitioners' services; dental care; prescribed drugs; sickroom supplies; special nursing services; X-rays, restorative services; prosthetic appliances; transportation; and special equipment. Nursing home care provided through money payment subject to special maximum.

Money payment to recipient.—Maximum on payment to recipient who is living in boarding or custodial care, or in a nursing home, $135; for persons living in a household, $165 for the household.

Source: Bureau of Family Services, Welfare Administration, Department of Health, Education, and Welfare.

Appendix E

Major Types of Services and Limitations

Medical assistance for the aged: Provision of major types of services under State plans, June 1963

Jurisdiction	Hospital care	Nursing home care	Physicians' services				Dental care	Prescribed drugs [1]
			Office	Home or in nursing home	Hospital			
					Outpatient	Inpatient		
Alabama	X	N	X	X	N	N	N	N
Arkansas	X	X	X	N	X	N	X	N
California	X	X	X	X	X	X	X	X
Connecticut	X	X	X	X	X	X	X	X
District of Columbia	X	X	N	X	X	X	X	X
Guam	X	X	N	X	X	X	X	X
Hawaii	X	X	X	X	X	X	X	X
Idaho	X	X	X	X	N	N	N	N
Illinois	X	N	X	X	X	X	N	N
Kentucky	X	X	X	X	N	N	X	X
Louisiana	X	X	X	X	X	X	N	X
Maine	X	N	N	N	X	N	N	X
Maryland	X	N	X	X	X	N	X	X
Massachusetts	X	X	X	X	X	N	X	X
Michigan	X	X	X	N	X	X	N	N
New Hampshire	X	N	X	X	X	X	N	N
New York	X	X	X	X	X	X	X	X
North Dakota	X	X	X	X	X	X	X	X
Oklahoma	X	X	N	X	X	X	X	N
Oregon	X	X	X	X	X	X	N	N
Pennsylvania	X	X	N	X	N	N	N	N
Puerto Rico	X	X	N	N	X	N	N	N
South Carolina	X	X	N	N	X	N	N	N
Tennessee	X	X	N	N	N	N	N	X
Utah	X	X	X	X	X	X	X	X
Vermont	X	N	X	X	N	N	N	N
Virgin Islands	X	N	N	X	N	N	X	X
Washington	X	X	X	X	X	X	X	X
West Virginia	X	X	X	X	X	X	X	X

[1] Other than for hospitalized patients; drugs for hospital patients are included as part of hospital care.

NOTE.—Code: X=service is provided; N=service is not provided.

LIMITATIONS ON SPECIFIC SERVICES

Hospital care

Alabama: For treatment of acute or major injuries; maximum of 30 days in fiscal year. Hospitalization for elective cataract surgery or for diagnosed cancer only if it is not available from some other sources.

Arkansas: To 30 days in fiscal year. Maximum daily rate $30.

District of Columbia: Limited to specified hospitals under contract with the Department of Public Health.

Guam: Limited to life-endangering or sight-endangering conditions or when prescribed by physician as "critically necessary."

Idaho: For care of acute conditions and emergencies only; 14 days per admission.

Kentucky: For care of acute, emergency, and life-endangering conditions only; 10 days per admission No limit on number of frequency of admissions.

Louisiana: Up to 30 days.

Maine: For essential care of chronic, emergency, and acute conditions up to a total of 45 days within a fiscal year; extensions possible only if it is determined that needed care cannot be secured outside a general hospital.

New Hampshire: No eye care.

Oklahoma: Care for conditions which endanger life or sight only.

Oregon: Up to 14 days per year. Patient pays $7.50 per day for first 10 days up to maximum of $75 per year.

Pennsylvania: Ward care only. Maximum rate $25.

South Carolina: Care only for acute illness, injury, or condition that endangers sight; not to exceed 40 days per year.

Tennessee: Care only for acute illness or injury or life-endangering illness whether acute or not, limited to 15 days per fiscal year. Patient pays the first $25 in any year.

Vermont: Recipient must pay first $7 a day for first 14 days in each period of hospitalization.

Washington: Care only for acute and emergent conditions.

Nursing home care

Arkansas: Up to maximum of $105 per month.
California: Available from 1st day of month following admission or upon transfer from county or county-contracted hospital. Maximum rate, $175.
District of Columbia: In District of Columbia Village Infirmary only.
Guam: "When available." (There are no nursing homes on Guam.)
Idaho: Up to maximum of $175 per month.
Louisiana: Only for persons eligible for OAA except for durational residence requirement. Up to $165 monthly.
Michigan: Only within 30 days following hospitalization for acute illness and limited to 90 days in a 12-month period.
Oklahoma: For medical care costs only; recipient pays own room and board.
Oregon: Upon transfer from hospital. Number of days available is based on hospital entitlement—14 days per year—with allowance of 4 days of nursing home care for each remaining day of hospital entitlement.
Pennsylvania: Only in institution operated by a county authority.
South Carolina: Following hospitalization. Ordinarily up to 90 days per year. Maximum payment, $150 per month.
Virgin Islands: Facilities not available.
West Virginia: After hospitalization or to prevent hospital care. Limited to acute conditions. Maximum payment, $135 per month.
Washington: Care only for acute or emergency medical conditions.

Physicians' services:

Alabama: Only in 30-day period immediately following release from hospital, limited to care related to conditions for which hospitalized; maximum of $15 for routine home or office visits.
District of Columbia: Limited to those provided by the Department of Public Health.
Guam: When prescribed as "critically necessary."
Idaho: Acute conditions; 2 calls per month. Nursing home: 1 call per month. 1 eye examination per 6-month period.
Illinois: Only in 30-day period immediately following release from hospital. Acute conditions: 1 home call daily for 1 week, 6 office calls per 30-day period. Chronic care: 2 home calls per month, 2 office calls per month.
Kentucky: 12 office and/or home calls per calendar year.
Louisiana: Serious continuing illness requiring care for relief of severe suffering or for correction or prevention of permanent impairment.
Maine: Only in "comprehensive clinic care" for patients with cardiac diseases, arthritis, circulatory and cardiovascular diseases, tumors, diabetes, or eye diseases that may result in loss of vision if not treated.
Michigan: Office services limited to emergency treatment, office surgery, and procedures involving therapeutic X-rays.
New Hampshire: 18 office and/or home calls per fiscal year; 14 inpatient calls per 30-day period, no payment to physician for hospital postoperative calls.
North Dakota: Inpatient hospital care of more than 30 days limited to 3 calls per week.
Oklahoma: Patients receiving nursing care: 2 calls per month. In hospital not more than 15 visits per month in certain hospitals, less in others.
Oregon: Patient pays first $50 of any combination of physicians' services, X-rays, or laboratory procedures; then eligible for maximum of $150 for physicians' care and maximum of $500 for surgery, $100 for X-rays and laboratory costs.
Pennsylvania: Only as provided through an approved home-hospital plan for treatment as "uninterrupted continuation of inpatient hospital care."
South Carolina: 3 clinic visits per month.
Utah: Generally limited to 2 calls in 30-day period.
Vermont: Limited to 6 home or office visits in any calendar quarter after recipient has paid for the first 6 calls in the quarter.
Virgin Islands: Available to patients under home care program.
Washington: Only for acute and emergent conditions.
West Virginia: Services must be related to acute and life-endangering conditions.

Dental services

California: Available only after discharge from 30-day period of institutional care—eligibility requirement for MAA.
Connecticut: Only for recipients who are under care in a medical facility such as a nursing home.
District of Columbia: As provided in selected Department of Public Health clinics.
Guam: For relief of pain only.
Kentucky: Services as related to relief of pain and treatment of acute infection. Up to $48 per year.
Maryland: Restorative dental care only, including repair and replacement of dentures.
North Dakota: Dentures and bridgework limited to when extractions occurred within previous 5 years.
Oklahoma: Only for in-hospital patients having life-endangering conditions involving: fractures, infections, or tumors of the mouth; by oral surgeon.
Washington: Limited to acute dental needs for relief of pain only; cost may not exceed $25.
West Virginia: Emergency treatment only.

Prescribed drugs other than for hospitalized patients

California: Limited to persons receiving nursing home or outpatient care.
District of Columbia: Only from pharmacies designated by Department of Public Health.
Louisiana: Only for patients in nursing homes.
Maine: Initial supply prescribed for diagnoses for which comprehensive clinic care may be authorized. (See above: Physicians' services.)
Utah: Up to $15 a month per person.
Washington: Only for acute and emergent conditions.
West Virginia: Limited to 1 refill for care of acute illness.

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